Treating Trauma:

A Grounded Theory study of professionals' experiences of working with sexual abuse in childhood

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Contents

Declaration

I declare that the work contained in this thesis is all my own.

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Date: 2.12.04

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Abstract

Therapists working with survivors of traumatic events are inevitably exposed to the shocking and emotionally painful experiences of their clients. In recent years attention has been turned to the impact of this work on these therapists. Research into the concept of 'vicarious traumatisation' (Pearlman & Saakvitne, 1995) has thus far sought to quantify levels of traumatic symptomatology among trauma therapists. This research however provides a limited account of the processes which might underlie such a phenomenon. Literature examining the experiences of therapists who work with adult survivors of sexual abuse suggests that particular dynamic processes within therapeutic work may contribute to this phenomenon. It is also suggested that work with child victims of abuse may be particularly difficult. There is, however, very little work examining the experiences of therapists working with these clients.

In the present study, a qualitative methodology was used to explore the experiences of ten therapists working in three Child Sexual Abuse teams in Central Scotland through open-ended interviews. Grounded Theory (Strauss & Corbin, 1998) was used to analyse interview material.

Two core categories emerged in this study. The first related to participants' responses to, and ways of coping within their work. The second encompassed aspects of therapists' emotional and psychological experiences outside the work context, which related to their experiences within it. These experiences were then interpreted from a psychodynamic perspective, relating them to processes of counter-transference and projective identification. It was suggested that the strength of these processes may be partly a facet of the particular dynamic and interpersonal challenges encountered in working with victims of interpersonal abuse.

The need to understand the longitudinal impact of engaging in this work was highlighted. In addition, it was proposed that assessment of the therapist's relational schema, in particular the impact of their attachment style on aspects of interpersonal functioning within the therapeutic relationship, might further inform understanding of the personal impact of this work.

1 Introduction

'The therapist as a person is a variable that cannot and should not be ignored'

(Lemma, 2003, p. 127)

In working with survivors of traumatic events, the therapist is unlikely to bear witness to actual physical trauma or injuries. However, through this work they will inevitably be exposed to accounts of the traumatic experiences of their clients (McCann & Pearlman, 1990; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). Indeed it is argued that to successfully ameliorate the pain and fear experienced by an individual following trauma, both must be continually confronted and experienced in therapy (Briere, 2002; Paivio & Laurent, 2001). Through such work the therapist is repeatedly faced with the emotional pain and, at times, shocking experiences characteristic of those who have suffered severe trauma (McCann & Pearlman, 1990; Nelson & Wright, 1996). In recent years, increasing attention has been paid to the experiences of those working in such a therapeutic capacity with victims of trauma. Responses such as burnout (Maslach, 1982) and 'compassion fatigue' (Figley, 2002) have been identified among helping professionals in general, though these effects are not confined to therapists working with traumatised clients. More specific to therapists working with trauma victims, is the observation of post-traumatic symptomatology, that is, evidence of affective, behavioural and cognitive responses similar to those of their clients (e.g. McLean, Wade & Encel, 2003; Pearlman & Mac Ian, 1995).

Both clinical research and observation have given rise to the conceptualisation of a phenomenon known variously as 'vicarious' (McCann & Pearlman, 1990) or 'secondary traumatisation' (Jenkins & Baird, 2002) among so-called 'trauma therapists'. The present study is concerned with underlying processes which may contribute to this phenomenon. The suggestion that, for therapists working with trauma victims, there is a set of primarily negative psychological and emotional

consequences associated with such work has clear implications not only for the therapist's mental well-being, but also for their clients and for those who are responsible for their management and supervision.

Before considering this proposition further, it is firstly important to consider the processes inherent in therapeutic work with victims of trauma which may underlie the hypothesised traumatisation of trauma therapists. This thesis is predominantly concerned with the experience of prolonged interpersonal abuse therefore subsequent references to trauma can be understood to refer to individual reactions to traumatic material and events that include processes of adjustment and affective adaptation.

1.1 Therapeutic process

Processes which occur between client and therapist are widely discussed and described (e.g. Lemma, 2003; Ligiéro & Gelso, 2002; Pearlman & Saakvitne, 1995). Particular dynamic processes such as transference and counter-transference are given varying levels of importance according to differing therapeutic models. The extent to which these are used to inform practice or are linked to the client's presenting problems also depends on their emphasis within the particular therapeutic model. These processes are generic and occur within any therapeutic context. However, it is suggested that in therapeutic work with trauma victims however they pose specific and unique challenges (Neumann & Gamble, 1995). These will be considered in the following discussion of therapeutic processes.

1.1.1 Transference

In psychodynamic theory the transference relationship is presumed to emanate from the client's early relationship experiences, particularly, though not exclusively, parental relationships (Pearce & Pezzot-Pearce, 1994). Transference describes the process by which a client's internalised object relationship is enacted in current relationships, in this case in their relationship with the therapist (Briere, 2002;

Lemma, 2003). In transference, the client therefore is regarded as drawing the therapist into a role which reflects their (the client's) internal world (Gabbard, 2001). This is generally accepted as occurring out-with the client's (conscious) awareness (Gabbard, 2001, Lemma, 2003). Broadly speaking, the role of the psychotherapist is to be receptive to such transference material and to interpret this both in the context of the client's early experiences and in relation to the present therapeutic relationship (Lemma, 2003).

1.1.2 Traumatic transference

Based on their early experiences of relationships, and resultant expectations of themselves and others, adults, and children, who have experienced abuse in childhood will bring these expectations and beliefs to new relationships, including the therapeutic relationship (Alexander, 1992). They will then interpret the actions of the therapist based on this previous experience and are likely to behave in a way which is unconsciously intended to provoke a repeat of their previous abuse or rejection (Pearce & Pezzot-Pearce, 1994). Such clients may therefore behave towards their therapist in an aggressive or attacking manner thus unconsciously re-enacting their early experience of an abusive relationship in the therapeutic relationship (Briere, 2002; Catherall, 1991; Herman, 2001, Gabbard, 2001). The client therefore 'transfers' on to the therapist their experience of victimisation in this early relationship and projects unwanted emotions that are evoked within the processing of traumatic experiences and memories onto the therapeutic frame and the therapist.

Other dynamics which can be re-enacted in therapeutic work with abused clients relate to the different representations of self-other relationships which they experienced in childhood. This can include acting 'as if' the therapist were the victim, the perpetrator or the non-protective bystander (Neumann & Gamble, 1995). Pearlman & Saakvitne (1995) describe other dynamics particular to working with victims of abuse which include their acute sensitivity in interpersonal relationships.

This is likely to have developed from an early need to be highly attentive to the needs of others. They also describe the potential for a client to idealise a therapist who they perceive as a benevolent or rescuing figure. That the therapist will, at times, be drawn into these dynamics is also seen as an inevitable aspect of trauma therapy (Pearlman & Saakvitne, 1995).

The role of the therapist's emotional responses to their client, including transference material, receives considerable emphasis in contemporary therapeutic literature (e.g. Norcross, 2001; Lemma, 2003) and is of particular importance to the present discussion.

1.1.3 Counter-transference

Within a psychodynamic model in contrast to a detached clinical stance, the therapist's emotional responses have been identified as a therapeutic tool to be used in the process of treatment, a means through which to enhance the therapist's understanding of the client's mind and unconscious communications (Lemma, 2003; Ligiéro & Gelso, 2002). Counter-transference therefore describes the emotional responses of the therapist to his client. Such responses may relate to the specific content of what a client brings and also includes the therapist's affective responses to the person, their emotions or behaviours within the therapeutic frame. This is distinguished from counter-transference behaviours which are overt manifestations of the therapist's emotional response (Ligiéro & Gelso, 2002).

Counter-transference responses occur within each therapeutic encounter. These responses vary across different therapeutic relationships and within them (Pearlman & Saakvitne, 1995). Such variety can be attributed to the fact that psychotherapy takes place within a relational context (Lemma, 2003). The therapist's subjectivity, personal needs and motivations (both conscious and unconscious) are brought to

their therapeutic relationship with each client (Gabbard, 2001). The therapist's subjectivity is therefore considered to colour the way in which a client's transference is experienced by the therapist (Gabbard, 2001, Pearlman & Saakvitne, 1995).

Aspects of a therapist's subjective experience which may be of particular importance are their relational schema, that is the organizing structures which influence patterns of relating to oneself and others (Briere, 2002). These inevitably have been shaped by the therapist's own early attachment experiences (Dozier, Cue & Barnett, 1994; Ligiéro & Gelso, 2002), although current understanding of the impact of these on the therapeutic process is limited and under-researched. A therapist's identity including gender, ethnicity, age and sexuality may also be of relevance. Current life circumstances and stressors will also influence the therapist's response to his/her clients (Pearlman & Mac Ian, 1995). These include satisfaction with intimate relationships as well as work-related identity and phenomenon such as knowledge, theoretical orientation, experience and perceived competence (Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). Many of these will be discussed further in relation to the notion of vicarious traumatisation.

1.1.4 Counter-transference responses to traumatic material

Affective responses which trauma therapists may experience include sadness, anger, fear, disgust and horror, often in response to abuse narratives (Knight, 1997). Feelings of helplessness, hopelessness, and guilt when witnessing the distress of an abused client are also common (Herman, 2001; Pearlman & Saakvitne, 1995). Having rescue fantasies or wishing to re-parent a client may act as a defence against feelings of helplessness or guilt for the lack of care a client received in childhood (Herman, 2001; Knight, 1997; Neumann & Gamble, 1995).

In addition to counter-transference responses, further evidence for the unique contribution of the self of the therapist lies in the domain of projective identification, an ego defence mechanism which is particularly potent in clients who have been victimised (Catherall, 1991).

1.1.5 Projective identification

In protecting the ego from being overwhelmed by strong, negative affect, projective identification describes an unconscious process in which unbearable emotions or aspects of the client's self are projected into another person, or object, in this case, the therapist (Lemma, 2003). By inducing in the other person thoughts or emotions which are the same or similar to those being projected, the client can relate to those, and control them, whilst disowning such feelings for himself (Catherall, 1991). The interactional quality of projective identification however (Lemma, 2003) rests in the notion that, as Gabbard (2001) describes, there must be a 'hook' within the therapist on which to attach the projected feeling. Thus the relative power of the projective identification will depend upon the extent to which the projected feeling resonates with disowned fragments of the therapist's identity or pre-existing psychological structures in the therapist's intra-psychic world (Catherall, 1991; Gabbard, 2001). The extent to which a client's projected feelings 'fit' with those of the therapist will therefore vary according to the specific therapeutic relationship (Gabbard, 2001), again highlighting the significance of the therapist's individuality within the therapeutic process.

1.1.6 Empathy

The concept of empathic engagement is regarded as fundamental to therapeutic relationships (Rogers, 1980). Therapist empathy is regarded as an essential context for therapy, and can communicate both understanding and acceptance of a client (Paivio & Laurent, 2001). It is suggested that in responding empathically to client's distress, therapists allow themselves to be touched by that distress without becoming emotionally overwhelmed. As Rogers (1992) describes, the therapist must find a

delicate balance between objectivity and identification. Such modelling of emotional regulation is particularly important to abuse survivors who often experience difficulties in attending to, or regulating their own affect (Briere, 2002; Paivio & Laurent, 2001).

1.1.7 Relevance to therapeutic work

'Counter-transference is part of every therapeutic relationship regardless of the therapist's theoretical orientation'

(Pearlman & Saakvitne, 1995, p.23).

The therapeutic processes previously discussed in general come from the psychodynamic literature. This thesis however is concerned with the experience of therapists who are not trained in, or practising psychodynamic psychotherapy. Nonetheless, it is argued that these processes remain relevant to all therapeutic relationships, particularly those with clients who have been abused. Briere (2002) proposes that for abused clients, engagement in a therapeutic relationship alone is likely to trigger relational schema, with their associated feelings and memories, which stem from their early, usually negative, interpersonal experiences. This would imply that, regardless of one's therapeutic approach, the therapeutic relationship will be affected by what the client transfers and subsequently projects from their early experience. With that, the meaningfulness of the therapist's counter-transference in such a therapeutic relationship is emphasised (Beutler & Hill, 1992).

The relevance of counter-transference is recognised within all theoretical traditions and, with that, the contribution of the therapist to the process of treatment (Norcross, 2001; Pearlman & Saakvitne, 1995). With the recognition of counter-transference as an inevitable and useful part of the therapeutic process (Gabbard, 2001) there are a number of implications for therapists. Taking a relational or constructivist approach to understanding the therapeutic process, the notion that the therapist's internal world

may contribute as much as the client's, has been suggested as placing the therapist in a vulnerable position (Gabbard, 2001). Despite his somewhat punitive view that the therapist's emotional responses were no more than an obstacle in the therapeutic process, Freud did however make provision for the therapist to be able to work through such difficulties in the context of personal analysis (Lemma, 2003).

In considering the current proposition that counter-transference responses are relevant to all therapeutic work, can it be presumed that all therapists are enabled or encouraged to address their responses in the context of supervision? Furthermore, can it be assumed that they will have access to external psychotherapy in which to explore personal issues? In this context we must accept therapists' vulnerability to potentially deleterious effects of their (unreflected) affective responses.

The impact on therapists of their therapeutic work will be considered in detail later. Given that the particular focus of the present study is on therapists who work with victims of childhood sexual abuse, the impact of this on the client, and therapeutic relationship, will first be explored.

1.2 The impact of childhood sexual abuse – a developmental perspective

The clinical presentation of adult survivors of childhood sexual abuse is increasingly understood in relation to the impact of abuse on the child's early development (Briere, 2002; Cole & Putnam, 1992; Finkelhor, 1984; Herman, 2001), in particular its relationship to early attachment experiences and developing attachment styles, affect regulation and reflective functioning (Alexander, 1992; Fonagy, 1998); the impact on interpersonal relationships and trust, and identity formation (Briere, 2002; Cole & Putnam, 1992; Herman, 2001, Pearlman & Saakvitne, 1995).

Although the abuse of children is not a new phenomenon, its recognition as a 'clinical problem' has occurred within the last fifty years or so. Childhood abuse as a problem with medical consequences was first identified in the 1960s (Kempe & Kempe, 1978). Sexual abuse as a specific form of child abuse, however, has only received attention since the late 1970s (Cole & Putnam, 1992; Kempe, 1978). According to Finkelhor (1984), official reports of child sexual abuse in the U.S. increased considerably during this time.

Childhood sexual abuse is defined as all sexual contact between an adult and a child (Berliner & Elliott, 1996). This includes penetrative acts, sexual touching or non-contact sexual acts such as exploitation, exposure or voyeurism (Kempe, 1978). In defining different types of sexual abuse of children, differences in psychological and relational outcomes for these children are also highlighted, with the acknowledgement that some will experience no adverse outcome (Alexander, 1992; Kempe & Kempe, 1978). That there is no uniform impact of sexual abuse in childhood, or predictable long-term sequelae, is related to the type, duration and timing of sexual abuse, in addition to concurrent developmental and environmental factors (Alexander, 1992; Berliner & Elliott, 1996; Browne & Finkelhor, 1986; Cole & Putnam, 1992; Kempe & Kempe, 1978; Mullen, Martin, Anderson, Romans & Herbison, 1993).

The developmental tasks faced by a child living in an abusive environment, particularly one in which sexual abuse occurs, include the formation of attachments to primary caregivers who are either neglectful or abusive, and the development of a sense of trust/safety (Cole & Putnam, 1992; Herman, 2001). The development of a sense of self in relation to others who are violent, neglectful or powerless may result in an internalised sense of self-blame or inherent badness which lasts well beyond childhood (Berliner & Elliott, 1996). The capacities for self-soothing and affect regulation are challenged by living in an unpredictable and often terrifying

environment (Herman, 2001). Further tasks include developing the capacity for initiative in an environment which demands complicity with an abusive figure, and development of the capacity for intimacy where intimate relationships are violated (Cole & Putnam, 1992). Finally, the child is challenged with developing a sense of identity whilst being identified as "a whore or a slave" (Herman, 2001, p101).

Unlike other forms of trauma, abuse in childhood often occurs in an interpersonal context, frequently within the family unit (Berliner & Elliott, 1996; Pearlman & Saakvitne, 1995). Intra-familial sexual abuse in particular is associated with psychological, affective and relational sequelae related to these interpersonal experiences (Cole & Putnam, 1992; Finkelhor & Browne, 1985).

The importance of attachment theory to understanding the impact of abuse is widely accepted (Alexander, 1992; Briere, 2002; Cole & Putnam, 1992; Fonagy, 1998, Pearce & Pezzot-Pearce, 1994; Pearlman, 1998). Early attachment experiences have been associated with the process of adjustment to abusive experiences and the mediation of the long-term impact of abuse (Alexander, 1992; Cole & Putnam, 1992; Styron & Janoff-Bulman, 1997). The role of attachment experiences in the development of relational schema and affect regulation is particularly salient to children who have been abused (Briere, 2002; Fonagy, 1998).

Attachment experiences can also be understood in terms of their contribution to the development of internal working models of attachment or core relational schema (Alexander, 1992; Briere 2002, Pearce & Pezzot-Pearce, 1994). Such relational schema are not verbally mediated. These implicit structures based on early experiences produce expectations about the self and others, and regulate responses in subsequent interpersonal interactions (Alexander, 1992; Briere, 2002; Fonagy, 1998). Early attachment relationships therefore form the prototype for interpersonal

relationships throughout life (Pearce & Pezzot-Pearce, 1994; Styron & Janoff-Bulman, 1997). Internal representations of the self and others are based on the child's inferences of their treatment by parents or caregivers. Where such parental care is abusive or neglectful, the child is likely to make negative self inferences and to see others as dangerous or rejecting (Briere, 2002, Pearce & Pezzot-Pearce, 1994). These relational schema then have an intrinsic impact on the individual's capacity to make and maintain meaningful relationships with others (Briere, 2002).

Attachment experiences are central in the development of affect regulation, particularly the regulation of negative and unwanted emotions (Alexander, 1992). In a positive attachment environment the child is able to experience uncomfortable internal states and, with the external security of a parent, develop strategies to tolerate and control negative affect (Briere, 2002). In the context of severe abuse however, such skills are less likely to develop. Exposure to intolerable emotional pain or abuse is potentially overwhelming to the child, thus extreme coping responses such as avoidance, thought suppression or dissociation are more likely (Briere, 2002; Fonagy, 1998). It is suggested that the reason some children experience a better outcome following sexual abuse, particularly one-off, extra-familial abuse, is related to their secure attachment and concomitant capacity for affect regulation (Briere, 2002).

Children who have experienced sexual abuse are more likely to develop an insecure, and often disorganised attachment style (Alexander, 1992; Fonagy, 1998). They are also likely to have experienced general disturbance in their relationships in terms of fundamental interpersonal functions of dependency, trust, safety, and control (Pearce & Pezzot-Pearce, 1994; Pearlman & Saakvitne, 1995). The challenge which they face as children, and into adulthood, is a combination then of core relational schemas based on negative, abusive experiences and a reduced capacity to control and tolerate the associated affect (Fonagy, Gergely, Jurist & Target, 2002; Briere, 2002).

The development of reflective function also occurs within the interpersonal context of early attachment relationships (Fonagy et al., 2002). This capacity to perceive and understand oneself, and others, in terms of mental states (thoughts, feelings, desires) arises in the context of sensitive care-giving, where the child recognises their own intentional stance in the reflective behaviour of the caregiver. Thus is dependent on the presence or absence of secure attachment (Fonagy et al., 2002).

Where such care is abusive or persecutory, the failure of caregivers to acknowledge a child's capacity for mentalising is compounded by a powerful disincentive to take the perspective of one who is hostile or abusive (Fonagy et al., 2002). The mental states of abusive and/ or neglectful others become threatening to the child's self-representation and Fonagy (1998) proposes that, at its most extreme, a child will turn off this capacity for reflective function as a defence. Given no other relational opportunities in which to develop the capacity to mentalise, this nonmentalising stance may come to dominate all interpersonal relationships, leading to severe interpersonal and psychological difficulties in adulthood (Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, Target & Gerber, 1996).

The psychological processes associated with avoidance and dissociation, which, in some ways, can be regarded as adaptive by allowing the child to survive in an early abusive relationship and environment, frequently become significant stumbling blocks in adulthood (Alexander, 1992; Berliner & Elliott, 1996; Briere, 2002). Breakdown of the defensive structure often at the developmental stage of secondary individuation/ separation i.e. a critical event for relational schema, may be the precipitant for referral to adult mental health services (Fonagy, 1998; Herman, 2001).

1.2.1 Links between childhood abuse and adult mental health

There is much evidence that childhood victimisation is a risk factor for later mental health problems (Berliner & Elliott, 1996; Briere, 2002; Browne & Finkelhor, 1986; Herman, Perry & van der Kolk, 1989). The impact of sexual abuse in childhood is manifest in the self and social domains in adulthood (Cole & Putnam, 1992). Adult symptomatology is likely to be influenced by the developmental stage at which abuse occurs due to the developmental processes discussed above (Berliner & Elliott, 1996).

Adult psychiatric disorders which are associated with child sexual abuse include borderline personality disorder, eating disorders, somatoform disorders, substance abuse in women, and multiple personality disorder (Cole & Putnam, 1992; Fonagy et al., 1996). These can be seen to share common themes reflecting the developmental impact of abuse as previously described. These relate to the intra-psychic processes of defining, regulating and integrating aspects of the self; and difficulties in the ability to experience trust and confidence in relationships (Briere, 2002; Cole & Putnam, 1992).

1.2.2 Psychotherapeutic issues

These studies highlight a significant shift in understanding and conceptualising adult psychopathology, which emphasises the importance of addressing early childhood experiences (Briere & Zaidi, 1989). This marks a paradigm shift in terms of treating people who have been sexually abused as children which moves from a medical model to a developmental one, thus shifting the emphasis from looking at aetiology to understanding meaning (Pearlman & Saakvitne, 1995). No longer are the psychological problems of these clients seen as being due to some inherent defect within the self (Briere, 2002; Herman, 2001).

Approaches to treatment emphasise the importance of validating the client's traumatic experiences and of integrating their traumatic memories with the associated affects (Alexander, 1992; Briere, 2002, Herman et al, 1989; Pearlman & Saakvitne, 1995). In that respect psychotherapy has become a key treatment approach by offering a developmental perspective on an individual's current difficulties. Given the violations of fundamental interpersonal functions which have occurred during childhood abuse, it is acknowledged that the process of treating survivor clients must occur within the context of a therapeutic relationship which disconfirms the internalised interpersonal expectations of the client (Briere, 2002; Catherall, 1991; Herman, 2001; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). For example, those adults who were child victims of interpersonal abuse experience difficulties in trusting others (Beutler & Hill, 1992; Finkelhor & Browne, 1985; Catherall, 1991). Within the therapeutic relationship therefore, trust cannot be assumed and, through this relationship, the client must experience and re-discover that others, i.e. the therapist, can be trusted (Briere, 2002; Catherall, 1991; Herman, 2001, Pearlman, 1998).

Interpersonal difficulties relating to the early abuse of dependency, trust, power, safety and projected or unacceptable aspects of the self are likely to be transferred into the therapeutic relationship (Catherall, 1991; Pearlman & Saakvitne, 1995). These may influence the client's engagement in the therapeutic process for example by sabotaging a positive relationship experience (Berliner & Elliott, 1996; Briere, 2002; Fonagy, 1998). The potential for such sabotage of therapy is made explicit within certain forms of psychotherapy with survivor clients, such as Dialectical Behaviour Therapy (Linehan, 1993), where actual or potential threats to treatment are actively addressed within the therapeutic process.

1.3 Impact on therapists of the therapeutic process

This overview of the developmental impact of abuse, particularly sexual abuse, is given to highlight the potential challenges and issues which may emerge in working therapeutically with those clients.

Participating in psychotherapy with victims of trauma has repeatedly been associated with negative psychological and emotional sequelae in the therapist (Knight, 1997; McLean, Wade & Encel, 2003; Neumann & Gamble, 1995, Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Steed & Downing, 1998). It is suggested that the difficulties this confers are different to those experienced when working with non-traumatised clients (Pearlman & Mac Ian, 1995). Pearlman & Mac Ian (1995) highlight that survivors of trauma have only recently begun to seek psychotherapy and it is this client group which is of particular relevance to the present study.

Within this literature there is a predominant focus on therapists who work with adult survivors of trauma, both physical and psychological. These studies tend to identify and define particular reactions to trauma work. The categorical definitions which appear most frequently in this literature describing the impact on therapists, include burnout (e.g. Maslach, 1982), Secondary Traumatic Stress (Jenkins & Baird, 2002) and Vicarious Traumatisation (e.g. McLean, Wade & Encel, 2003; Pearlman & Mac Ian; 1995; Schauben & Frazier, 1995). Sabin-Farrell & Turpin (2003) provide a useful overview of these concepts and the limitations thereof.

These studies also attempt to differentiate between reactions which are particular to those working with victims of trauma versus those which may be experienced by any therapist, or, for that matter, 'caring professional'. Although this effort to consider the specific experiences of trauma therapists perhaps suggests that these researchers are aware of specific difficulties associated with this type of therapeutic work, the

conclusions which can be drawn from this research are limited. One reason for this would seem to be the apparent overlap in the reactions reported by therapists in these studies. That is, different quantitative measures of symptomatology appear to measure similar phenomenon/ reactions in therapists (e.g. Jenkins & Baird, 2002; McLean et al., 2003).

Furthermore, the reliance on quantitative research methods limits the understanding of what it is about trauma therapy which might result in such consequences for the therapist. For example, the sampling within these studies often relies on self-selected participants who identify themselves as 'trauma therapists' (e.g. Pearlman & Mac Ian, 1995). Given that 'trauma' is a broad construct encompassing the experience of a one-off car accident to that of, for example, sustained ritualistic sexual abuse in childhood, it is difficult to conclude from such studies the extent to which the reported impact on therapists is related to specific aspects of the therapeutic dynamic, which would be distinctly different with victims of such varied traumatic experiences. Potential biases in the findings are also recognised due to the use of self-selected participants whose possible motivation for participating in such research e.g. that they feel particularly stressed, may be what is reflected in the results rather than evidence of a phenomenon which can be generalised to all therapists working in this field (McLean, Wade & Encel, 2003). McLean, Wade & Encel (2003) also highlight that in most of the studies considering therapist traumatisation, participants have not been asked about the occurrence of a recent or directly traumatic event in their personal lives. Thus, they argue, it is not possible to ascertain whether symptoms characterised as indicative of traumatisation have arisen from such direct traumatic experience or their therapeutic work.

In response to such criticisms, and because the focus of this thesis is on therapists who work with child victims of sexual abuse, the next sections in this introduction will consider the particular experiences of therapists working with this form of trauma, both in adult survivors and child victims.

Much of the theoretical literature looking at the experiences of therapists who work with adult survivors of childhood sexual abuse focuses on the concept of vicarious traumatisation (Pearlman & Saakvitne, 1995). This will now be considered both for its focus on sexual abuse survivors and because, unlike the quantitative research previously described, it provides one possible framework for understanding the process and mechanisms by which therapists are hypothesised to become traumatised by their work with survivors of abuse.

1.3.1 Vicarious traumatisation – a process of therapist traumatisation?

Vicarious traumatisation (VT) is delineated as a distinct consequence of engaging in therapeutic work with victims of trauma and has specific negative consequences for the individual (Pearlman & Saakvitne, 1995). VT is considered to be both a 'normal' (Neumann & Gamble, 1995) and 'inevitable' consequence of engaging in trauma therapy (Pearlman & Saakvitne, 1995). Its effects are regarded as pervasive, in that it impacts on the therapists' emotional responses both within and outside of work (McCann & Pearlman, 1990).

Vicarious traumatisation of therapists is evidenced by changes in their beliefs about the world, their identity and psychological needs relating to safety, trust, intimacy, control and esteem (Pearlman & Saakvitne, 1995). It is said that this cognitive change impacts on the therapist's personal life because it affects their emotional responses and relationships e.g. by developing altered schemas about trust, the therapist then begins to question the motives of others (McCann & Pearlman, 1990). Experiencing intrusive traumatic imagery may also be symptomatic of VT (Pearlman & Mac Ian, 1995).

Vicarious traumatisation is defined as "the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients'

trauma material" (Pearlman & Saakvitne, 1995, p.31). It is seen as being as specific to traumatic material due to the exposure of the therapist to horrific images and accounts of disturbing events, including intentional cruelty between people, and during therapy, witnessing and participating (albeit unintentionally) in re-enactments of traumatic dynamics within therapy (Pearlman & Mac Ian, 1995; Neumann & Gamble, 1995).

Pearlman & Saakvitne (1995) regard VT as being a cumulative process, that is, through the repeated exposure to, and engagement, with clients' traumatic material, the therapist's worldview becomes altered. Such changes to the therapist's psychological structures, which are inevitably negative, increase the therapist's vulnerability. Thus, it is proposed, continued exposure to traumatic material leads to vicarious traumatisation of the therapist.

Pearlman & Saakvitne (1995) go on to highlight the importance of the therapist's subjective experience within this process. Adopting a constructivist self-developmental model to explain vicarious trauma they propose that there is an interaction between the unique psychological characteristics of the therapist and the characteristics of the situation i.e. of the therapy dynamics, traumatic material and so on (Pearlman & Saakvitne, 1995). McCann & Pearlman (1990) posit that it is the salience of the therapist's schemas particularly around trust, intimacy, power and esteem which determines the particular responses of the therapist to hearing traumatic material. They go on to suggest that it is the degree of discrepancy between the client's material and the therapist's schemas which will determine the particular disruptions experienced by therapists.

This brief outline of vicarious traumatisation highlights two important aspects; one is that part of the proposed process may relate to aspects of the dynamic processes

within therapy e.g. re-enactment, and secondly it is important to consider the therapist's individuality in their responses to their work.

The evidence for vicarious traumatisation is limited and at times, discrepant (Sabin-Farrell & Turpin, 2003). As previously described, attempts to study this using quantitative methods are restricted, not least because it is difficult to extrapolate a potentially developmental process from a cross-sectional design or to ascertain the permanence of reported reactions, such as altered beliefs.

The two qualitative studies in this area also find evidence of the cognitive and affective changes associated with vicarious traumatisation (Benatar, 2000; Steed & Downing, 1998). That therapists also report positive aspects in their work with abuse survivors was highlighted in both studies. These authors present and interpret their findings within the categorical definition of vicarious traumatisation and, as such, view their findings as further evidence of this. However these studies add little to our understanding of the hypothesised process of traumatisation. Indeed Steed and Downing (1998) conclude that there is a need for longitudinal research to understand the cumulative effects of vicarious traumatisation.

Schauben & Frazier (1995) discuss the 'reasons' why working with survivor clients is difficult. They describe that it is difficult to hear stories and experience the person's pain which, it can be inferred, relates to the empathic process. Qualitative data collected in this study highlighted that difficult aspects of the work included the therapists' experiences of therapy with clients, such as establishing a trusting relationship. Their capacity to deal with clients' emotions about their abuse, i.e. their counter-transference reactions, was also identified as another difficult aspect of this work. Although the conclusions which can be drawn from their study are limited, it

would seem to highlight the importance of the therapeutic relationship and dynamics within that, as part of the proposed process of vicarious traumatisation.

Evidence of vicarious traumatisation outside therapeutic work also highlights a possible role for dynamic processes which may be of relevance to it. Nelson & Wright's study (1996) of post-traumatic symptomatology in the partners of Vietnam veterans outlines a process of vicarious traumatisation which involves over-identification with the emotional reactions of the victim and internalisation of, for example, their partner's traumatic imagery, such that the partner then experiences these as their own.

In relation to the therapists' individuality, Marmaris, Lee, Siegel & Reich (2003) found a significant relationship between therapist's self-reported attachment style and vicarious traumatisation, such that those with a fearful or preoccupied attachment style experienced greater cognitive disruption and symptoms of avoidance, intrusion and hyperarousal. This would suggest another important yet relatively neglected aspect to consider within this process.

In a curious, almost parallel, process to the way in which particular types of adult psychopathology, which can now be understood to be the developmental consequences of childhood abuse, were first conceptualised and treated, it would seem that this new and burgeoning literature on the experiences of trauma therapists also demonstrates a rapid need to identify, and then ameliorate, symptoms of this hypothesised traumatisation. What seems to be lacking however, is a thorough understanding of the development of such 'symptoms', of the impact of particular therapeutic dynamics and the role of the therapist's subjective experience within that.

1.4 Contextual factors influencing therapists' experiences

As the previous overview of vicarious traumatisation implies, some of the reactions which therapists experience may not be a direct consequence of their therapeutic work. In this section, other facets of abuse work and the therapist's individuality which may influence this process will be considered.

1.4.1 Societal

'Hysteria is the combat neurosis of the sex war'

(Herman, 2001, p32)

Interest and research in the psychological effects of trauma is regarded as having three phases (Herman, 2001), beginning with Freud, whose early investigations into classic hysteria led him to conclude that it was related to premature sexual experiences (Lanyado, 1999). Freud however was regarded as retracting this theory due to what it implied about society at that time (Herman, 2001).

Research into sexual assault, and increased recognition of childhood sexual abuse, only began in the United States in the mid 1970s, despite awareness that the sexual victimization of women and children has a far longer history (Finkelhor, 1984; Herman, 2001). Lanyado (1999) describes the influence in the United Kingdom of investigative journalism during the 1980s on public awareness of the sexual (and physical) abuse of children which, she infers, seemed to precede the referral of such clients to Child and Family mental health services. By implication, it is neither the prevalence or incidence of abuse, particularly sexual abuse, which has altered over the past century. Rather, it would appear to be society's acknowledgement, acceptance and interest in abuse (often driven by the media) which defines the status and experience of victims (indeed whether their trauma is acknowledged at all).

Societal responses to childhood sexual abuse including silence, secrecy, attempts to deny its prevalence and impact, not only mirror the experiences of victims, but may

also impact on the therapist by contributing to a sense of isolation (Pearlman & Saakvitne, 1995). This may be echoed within professional life if colleagues themselves deny the impact of childhood trauma thus negating the work or importance of these therapists (Illife & Steed, 2000). The reactions of people in the therapist's personal life to their work with victims of abuse may include horror, disgust, idealisation or disbelief. All of which have the potential to impact upon the therapist's personal and professional identity (Neumann & Gamble, 1995).

1.4.2 Personal

1.4.2.1 Therapist' s abuse history

The prevalence of abuse history in helping professionals, particularly those who work with traumatised clients, is difficult to establish and estimates vary between 30 (Follette, Polusny & Milbeck, 1994) and 68% (Stevens & Higgins, 2002). A therapist's experience of abuse may influence the therapeutic frame significantly in their identification and particular counter-transference reactions (Beutler & Hill, 2002).

For those therapists who have experienced abuse, it could be argued that their schemata about self and world (and actual experiences) may be more concordant with the traumatic memories and affects of their clients and arguably they may experience less significant changes in their schemata, although of course this would depend on the extent to which they have reconciled their abusive experiences. Other issues for survivor therapists include over-identification (Pearlman & Saakvitne, 1995). McCann & Pearlman (1990) emphasise that unresolved issues do not always underlie the reactions of therapists to traumatic material. However, such unresolved issues, particularly relating to personal experiences of victimisation, might contribute to the process of vicarious traumatisation.

Other problems may exist in relation to the negative transferences from clients, particularly that of the therapist as perpetrator. This may be particularly salient and

distressing to a survivor therapist who has a strong conviction never to be in an abusive role as a result of their own abuse (Pearlman & Saakvitne, 1995).

It seems that in the literature there is some degree of confusion as to whether survivor therapists are indeed at greater risk of the negative effects of trauma therapy. This may in part be due to methodological issues such as poor definition of what constitutes a trauma history and the particular constructs which have been operationalised.

Those therapists working with survivors of sexual assault who themselves had a previous history of traumatisation were not significantly more distressed in terms of PTSD symptomatology, negative affect or burnout than their non-survivor counterparts (Schauben & Frazier, 1995). In this study it was reported that some participants found that the process of counselling victims enabled them to deal with their own experiences of past victimization. Little & Hamby (1996) suggest that therapists with a history of childhood sexual abuse may have difficulties with boundary issues, such as disclosure, although emotional responses to abuse were not found to differ according to abuse history.

In her qualitative study of the experiences of therapists with and without a history of CSA, Benatar (2000) reports that there were no notable differences between the two groups in terms of vicarious traumatisation. All participants were found to report some level of distressing or disruptive phenomena and those with a history of childhood sexual abuse were not found to be any more vulnerable, nor resilient than their non-traumatised counter-parts. It is argued however that in this sample of 'experienced' therapists (minimum 7 years of experience), the process of training, supervision and personal therapy may have decreased the vulnerability of therapists

with an abuse history. Alternatively, the more vulnerable may have in fact opted out of the profession.

The role of a therapist's abuse history in vicarious traumatisation appears unclear. Given that adaptation to abuse, particularly occurring in childhood, is influenced by several factors (developmental timing, type, duration) it is perhaps not surprising that there is no uniform impact of this on the survivor therapist's experience of trauma therapy.

1.4.2.2 Gender

The traditional and prevalent view of men as perpetrators of abuse cycles may impact upon the therapists' experience according to their gender. A male therapist for instance may experience over-identification with the aggressor (Herman, 2001). As women are more frequently victims, female therapists may therefore find themselves identifying with the female victim and possibly experiencing strong anger towards the perpetrator (Pearlman & Saakvitne, 1995; McCann & Pearlman, 1990). Little & Hamby (1996) report significant differences in clinical practice based on gender. Specifically, female therapists experience more counter-transference reactions and find therapeutic abuse work more difficult than their male counterparts. It can be seen then that the process of identification may be important in the therapist's, and client's experience of therapy.

1.4.2.3 Professional identity

'Trauma therapy challenges the helper identities of all therapists'

(Neumann & Gamble, 1995, p.344)

It is suggested, however, that those newest to the professional role may be the most vulnerable to the effects of powerful counter-transference. This is thought to be due to a lack of awareness of unconscious processes. This is combined with a vulnerable

sense of professional identity, such that, in experiencing clients' projections or unconsciously participating in re-enactments in therapy, the new therapist's counter-transference is thought to interact or resonate with feelings of inadequacy related to being a new therapist (Neumann & Gamble, 1995). This is thought to increase their vulnerability to being traumatised by their work. It is suggested that due to perceptions of the need to cope/ not fail, new therapists may find it more difficult to disclose emotional difficulties (Neumann & Gamble, 1995). Knight (1997) found that those more likely to report feeling overwhelmed by their work with survivor clients had less experience. McLean, Wade & Encel also (2003) found that newer therapists were more susceptible to avoidance and symptoms of intrusion than more experienced colleagues.

One would argue that, for any therapist whose personal/professional identity is based on being a benevolent, non-abusive figure, the experience of being identified with an abuser by a client is likely to be damaging if not addressed. This could increase vulnerability to therapist traumatisation if this leads to re-enactment within therapy, for example by the therapist becoming dominant or controlling of the client who feels re-victimised (Pearlman & Saakvitne, 1995).

1.4.3 Structural context

1.4.3.1 Supervision

The importance of supervision in trauma work is emphasised throughout the literature (e.g. Azar, 2000; Herman, 2001; Marmaris et al., 2003; McLean et al., 2003; Neumann & Gamble, 1995, Pearlman & Saakvitne, 1995). In addition to discussing technical or intellectual issues about therapy, the importance of being permitted to express and process emotional reactions to this work is also highlighted (Herman, 2001; McCann & Pearlman, 1990). Supervision or personal therapy is essential in highlighting and reflecting upon processes, such as identifications and

particular counter-transferences, which often occur unconsciously (Sabin-Farrell & Turpin, 2003) and are pertinent to the possible traumatisation of therapists.

1.4.3.2 Peer support/professional isolation

Trauma therapists can experience a sense of alienation within the work which may be reinforced by colleagues, or acquaintances outside work, who question their motives or capacity for doing the work (McCann & Pearlman, 1990). A sense of isolation may be further perpetuated by the limits of confidentiality which preclude disclosure of client material (Azar, 2000).

Much of the literature which has been discussed in relation to the impact of abuse-focused therapy on the therapist, concerns those who work with adult survivors of abuse. This points to aspects of the therapeutic relationship and wider dynamics, such as societal attributions, which may contribute to the therapist's experience of this work. This leads then to the present study, and to the question of whether these processes are relevant to those who work therapeutically with child victims of sexual abuse, and what is the impact of such work upon them?

1.5 The impact of working with sexually abused children

'The therapist working with the sexually abused child has first to face personal issues: in a sense, the fact that the abuse cannot be mended. We work often in NHS teams where 'treatment' and 'cure' are concepts used daily. Yet trauma cannot be undone; the now sexualised child cannot turn back from adult awareness and the experience of being a child has been corrupted. The challenge to omnipotence in the clinical team is great and may be one of the reasons why the work is so stressful'

(Horne, 1999, p354).

From the literature looking at therapists who work with adult survivors of sexual abuse (e.g. Pearlman & Saakvitne 1995, Steed & Downing, 1998) it is highlighted that these therapists, as a result of their therapeutic work, may experience increased safety fears for their own children. Many of these therapists state that they find it

particularly difficult to hear about the abuse of children (Iliffe & Steed, 2000; Schauben & Frazier, 1995). Indeed it is proposed that clinical work with children puts therapists at particular risk of 'burnout' (Azar, 2000) or 'secondary traumatic stress' (Cornille & Meyers, 1999). Reactions to the abuse of children then are strong, even to those not involved in direct work with them. There is however a dearth of literature which considers the impact on therapists of working specifically with this client group (McLean, Wade & Encel, 2003). It is suggested nonetheless that the psychotherapeutic dynamics in therapy with children who have been abused will be similar to those with adults i.e. their internal representations of early relationships will be manifest in the therapeutic relationship, which is consistent with transference (Pearce & Pezzot-Pearce, 1994).

Reactions to working with abused/ traumatised children are documented in a small number of studies, many of which, however, include professionals in non-therapeutic roles. These studies, like those in the adult literature, tend to categorise reactions, and find high levels of, for example, 'burnout' (Shapiro, Dorman, Burkey & Welker,1999; Stevens & Higgins, 2002) and 'clinical levels of emotional distress' (Cornille & Meyers, 1999). These studies conclude however that their results may be accounted for by other reasons, such as experience of actual trauma, and that further information is needed to understand the process by which some workers but not others develop symptoms of traumatisation.

Dyregrov & Mitchell (1992) consider the role of certain 'personality' characteristics of the person who works with traumatised children. They identify two which are seen as characteristic of those working in this field. One is the tendency for individuals to have a high level of personal investment in being a helper. The other is possible identification with child victims stemming from an individual's unconscious memories of their own childhood or identification with the victim's family. It is suggested that personnel can easily imagine their own loved ones as victims of

trauma and consequently experience increased fears for the safety of their own children. The extent to which these are permanent transformations within the individuals is however unclear.

The authors propose that a desire to 're-parent' child victims may be a risky characteristic, especially for those involved in long-term caring relationships with such children. Similarly Azar (2000) identifies that therapists working with children may have adoption fantasies. Such counter-transference responses may be an indication then of the particular dynamics of working with abused children which instil strong feelings in the therapist, for example, guilt for the child's lack of care.

Studies looking at staff who work with children who have been sexually abused or maltreated suggest that this may have negative impact on them. However, the conclusions are limited due to the small number of studies. Also, the samples are of questionable representativeness: that is, they include heterogeneous groups of professionals working with child victims including, for example, administrators (Shapiro et al., 1999). This dilutes the conclusions which can be drawn with regard to the possible impact of therapeutic work.

This leads then to the rationale for the present study. There is a lack of literature on the experiences of therapists who work directly with sexually abused children. Theoretical literature, particularly pertaining to those who work with adult survivors of childhood sexual abuse, suggests that such work may have negative consequences for the therapist. However, conceptual understanding of the process of such traumatisation is limited and complex, relating, it seems, to aspects of the therapeutic process as well as the therapist's individuality.

1.6 Research aims

The broad research question is, therefore, to examine whether working therapeutically with child victims of sexual abuse brings about similar or different experiences to those of therapists who work with adult survivors of such abuse. To

answer this question, a qualitative research methodology, Grounded Theory (Strauss & Corbin, 1998) will be used. The rationale for this is that, as an under-researched area, there are no pre-existing hypotheses to be tested. Rather, the interest is to explore the experiences of participants and to discover processes within those experiences. Furthermore, the use of Grounded Theory to analyse material from open-ended interviews allows the emergence of unexpected themes (Charmaz, 2003a). A constructivist approach to Grounded Theory will also be adopted, allowing identification of the researcher's stance as a participant in the research process, as against distant observer of it (e.g. Charmaz, 2003a).

The aims of the present study therefore are to:-

1. initially explore the experiences of therapists working specifically with children who have been sexually abused.

2. develop hypotheses regarding the impact of this work on therapists, based on their interview material, which will be tested out through further interviews.

3. build a theory of the lived experiences of the participants

2 Methodology

2.1 Design

This study utilised a qualitative design. Each participant took part in an in-depth, open-ended interview. Interview transcripts were analysed according to the principles of Grounded Theory (e.g. Charmaz, 2003a; Strauss & Corbin, 1998). In addition, the author kept a personal journal, or reflexive ethnography, (Ellis & Bochner, 2003) documenting her experiences of working with children and young people who have been sexually abused and of the research process.

2.2 Research context

In Central Scotland there are three dedicated NHS Child Sexual Abuse Teams and a network forum has been established for a number of years to which these teams are invited to attend. Meetings take place approximately every two months and consist of an information sharing/discussion time followed by a presentation on an abuse-related topic. The aim of meetings is to facilitate support and communication between the teams. At this forum, practitioners in the field had previously expressed an interest in participating in a formal research project considering the impact upon themselves of working with children and young people who have been sexually abused. The idea for the present study therefore was generated by members of the wider Child Sexual Abuse network and, as such, reflects a professional concern with issues relating to the personal impact of their therapeutic work.

2.3 Participants

The study participants were ten practitioners currently working in three dedicated NHS Child Sexual Abuse teams in Central Scotland. Inclusion criteria were that they were working at least part-time within one of the three Child Sexual Abuse teams. This reflects the fact that most practitioners in the three teams in Central Scotland do not work full-time with sexually abused children and young people.

Sampling was purposive, specifically theoretical sampling was used, as defined by the principles of Grounded Theory, to develop emerging categories and refine ideas (Barker, Pistrang & Elliott, 2002; Charmaz, 2003a; Strauss & Corbin, 1998). Consequently interviewees in this sample varied in their professional trainings and the length of their experience working with sexually abused children and young people, reflecting the breadth of experience within the three teams. Brief demographic information was requested after the interviews. This is tabulated at the beginning of the results section.

2.3.1 Team profiles

To orient the reader to the composition and work of the Child Sexual Abuse teams, a brief profile of each is provided.

Team 1 – Centre for the Vulnerable Child, Fife (since 1994)

Team composition

2 nurse therapists, 1 seconded mental health nurse, 3 clinical psychologists, 1 trainee clinical psychologist, 1 art therapist, 1 counsellor and 1 vacant post.

Whole time equivalent = 7.6

Referral criteria

- No minimum age up to 18 years.
- Referrals taken from Social Work/ Health Visitors/ Child Protection Unit/ GP/ Child & Adolescent Mental Health Service.
- This is a post-investigative service therefore all allegations of abuse must have been passed on to the Child Protection Unit before being seen.
- Child/ young person has expressed a desire to attend for counselling/support.

Therapeutic approaches offered

Long-term play therapy, art therapy, psychodynamic counselling, and family therapy.

Groups not currently offered - have been provided in the past.

Other services provided

Monthly consultations open to social workers, education and health workers.

Monthly consultancy to fostering and adoption service.

Therapeutic work with children or young people displaying sexually inappropriate behaviour.

Teaching, training and supervision.

Team 2 – Sexual Abuse Team, Young People's Unit, Edinburgh (since 1990)

Team composition

1 nurse therapist, 1 clinical psychologist, 2 mental health practitioners (social work trained) and 1 occupational therapist.

Whole time equivalent = 1.1

Referral criteria

- Age 14 to 18 years.
- Referrals taken from Social Work/ GP/ Out-patient teams at Young People's Unit. Urgent referrals from hospital accident and emergency department.
- Investigation of abuse has usually been done, or can be seen post-disclosure.
- History of abuse with specific symptoms indicating psychiatric disturbance.

Therapeutic approaches offered

Cognitive-behavioural therapy, interpersonal psychotherapy, dialectical behaviour therapy, psychodynamic counselling and family therapy.

Groups not currently running - have been offered in the past.

Other services provided

Monthly consultation to the young people's in-patient unit.

Team 3 – Child Sexual Abuse Team, CAMHS, Rillbank, Edinburgh (since 1997)

Team composition

2 nurse therapists, 1 clinical psychologist, 3 social workers and 1 occupational therapist.

Whole time equivalent = 3.5

Referral criteria

- Age up to 14.
- Referrals taken from Social Work/ GP/ SCAN clinic (forensic medical team)/ Police/ Educational Psychology.
- Post-investigative.
- History of sexual abuse/ assault.

Therapeutic approaches offered

Abuse focused therapy with abused children and their families, informed by several models including cognitive-behavioural therapy, psychodynamic therapy, play therapy and family therapy.

Groups not currently running - have been offered in the past.

Other services provided

Teaching and training.

Supervision to other professionals.

Contribute to consultation clinics (CAMHS & other services).

2.4 Procedure

Two pilot interviews were conducted prior to the commencement of data collection. The interviewees for the pilot interviews were a clinical psychologist and a nurse therapist who had previous experience of working in an NHS Child Sexual Abuse Team, thus maximising the credibility and relevance of the pilot interview material. They were approached by the author who explained the present study, and asked if they consented to a pilot interview. They were informed that material from the pilot interviews would not be used in the present study. The aim of the pilot interviews was to familiarise the author with the particular interview format. Both pilot interviews were transcribed verbatim by the author and reviewed with the academic supervisor, focusing predominantly on the author's style of interviewing and discussing difficulties encountered in the process.

2.4.1 Participant selection

General consensus for the research had previously been given within the network meetings described above. Prior to commencing data collection, the author met with two representatives from each team. The proposed format for the interviews was described and discussed with them. Each team representative, including the author, discussed the research with their specific team. An information sheet was also circulated to all team members outlining the purpose and nature of the interviews (Appendix I). At this stage all team members were given the opportunity to raise any queries or concerns about the study and asked about their willingness to participate in the research. The author then met again with the two team representatives to ensure that the research had been discussed with each team and to clarify that general consent had been given.

Each participant was then contacted by the author directly, who explained the purpose of the research and gave them the opportunity to ask further questions about the project. If they then chose to participate, an interview was arranged. Interviews took

place no less than 72 hours later to allow participants time to reconsider and, if necessary, withdraw their consent.

2.4.2 Interview format

After two interviews were conducted, new or developing themes were identified and carried into the next pair of interviews. In accordance with the principles of Grounded Theory interviewing (Charmaz, 2003b), the range of topics became more specific as the research progressed. However, two main themes which all participants were asked about were:-

- How they had come to be working with children and young people who had been sexually abused
- Any personal impact they had experienced in relation to their work

The framework for the follow-up and probe questions was informed by principles of qualitative interviewing as described by Barker, Pistrang & Elliott, 2002; Charmaz, 2003a & 2003b; and Rubin & Rubin, 1995. These were intended to encourage interviewees to describe their experiences in detail, to gain an understanding of the meaning of those experiences for the individual, and to gain an impression of whether, and how, their thoughts and feelings about their experiences had changed over time.

Interview setting

Participants were interviewed at their place of work in a room chosen by them. The interviews were conducted between January and May 2004.

2.4.3 Data management

All participants agreed to their interviews being audio-recorded. The recordings were transcribed verbatim by the author. Digital audio recordings were erased from the memory of the recording device after having been saved to computer. The voice files

were stored on the author's computer to allow constant interaction with the interview material. Transcripts were anonymised for presentation in this thesis.

2.5 Data Analysis

2.5.1 Methodology employed

A qualitative design was selected for the present study as it allows complex aspects of individual experience to be studied whilst imposing fewer restrictions than a quantitative methodology (Barker, Pistrang & Elliott, 2002; Denzin & Lincoln, 2003; Strauss & Corbin, 1998). Qualitative interviewing allows exploration of an aspect of life about which the interviewee has both experience and insight (Charmaz, 2003b). Furthermore, interviewing is an emergent technique, the flexibility of which enables the interviewer to pursue issues as they emerge in the interview i.e. is not bound by a prescribed format or protocol (Charmaz, 2003b). By means of the interviews the author was able to explore several themes pertinent to the interviewees in a systematic way.

Grounded theory describes both a method of analysing data and the product of the research, that is, a theory which is grounded in the data or empirical material (Strauss & Corbin, 1998). It is therefore an emergent process which is not based on pre-existing questions or hypotheses (Charmaz, 2003a). It is inductive in nature, that is, categories, themes and patterns come from the data (Janesick, 2003) and is concerned with discovering process (Strauss & Corbin, 1998) and understanding participants' experiences and personal meanings (Barker, Pistrang & Elliott, 2002). Within this methodology, the influence of the interviewer's previous knowledge and understanding on the interviews is acknowledged.

Autoethnography describes a process used within much social science research in which the researcher, who is 'native' to the 'culture' under study, uses a form of

personal record (reflexive ethnography) to illuminate the study (Ellis & Bochner, 2003). In this respect the present author was uniquely placed, as a final year clinical psychology trainee who had chosen to work in a dedicated Child Sexual Abuse team for her final year placement, to record her experiences of coming into the work. These reflections therefore became part of the process of data collection and the analysis.

2.5.2 Analysis process

According to the principles of Grounded Theory espoused by Strauss & Corbin (1998) and those of Charmaz (2003a, 2003b), interview data was analysed in a pair-wise method through which developing themes were identified and carried into the next pair of interviews. In this respect data analysis was an on-going process. The data were managed with the use of QSR Nud*ist software for social research.

The development of categories using Grounded Theory relies on a constant comparative method, that is moving between data which has been collected and incoming material (Strauss & Corbin, 1998). The coding of data involved a two-step process. The first was to code transcripts in an open way, allowing the identification of general categories or themes from the data. As coding is an inductive process, the categories, themes and patterns which emerge require interpretation as these are not imposed a priori (Janesick, 2003). This led to the second stage of selective or focused coding, in which all the transcripts were re-analysed applying the framework of categories developed in the first stage, both refining and extending these according to the interview material.

Within the constructivist paradigm adopted here (see Charmaz, 2003b), the author's stance as interviewer is acknowledged, both in relation to the interview process and the analysis of interview data. As Charmaz explains, "the viewer then is part of what is viewed rather than separate from it" (2003a, p. 273). It is therefore emphasised that

the analysis of interview material and resultant coding system reflect the author's interests and perspectives as well as the content of the interviews.

2.6 Reliability and validity

The reliability and validity of themes is considered an inherent aspect of the methodology in that these were not assumed by the interviewer. Themes, once identified, were taken into the next interview and this process was repeated until the point of saturation (Strauss & Corbin, 1998). This is the point at which interview material on a particular theme provides no new aspect or understanding to it.

The development of categories and coding was discussed with the author's academic supervisor who acted as an additional analytic auditor (Elliott, Fischer & Rennie, 1999).

The author's thoughts and observations on the research process were recorded in a personal journal which provided the opportunity for reflection on biases and assumptions.

The present findings will be fed back to three Child Sexual Abuse teams. Due to time constraints this could not be done prior to submission of this thesis however this is considered an integral part of assessing the credibility of the categories which have been developed (Elliott, Fischer & Rennie, 1999).

2.7 Ethical issues

Prior to commencing the study, the chairperson of the Ethics committees for the two health boards where the Child Sexual Abuse teams are located (Lothian and Fife) was contacted. Both chairpersons asserted that it was not necessary for formal ethical approval to be sought as the participants were staff and could be regarded as healthy volunteers.

Possible ethical issues associated with taking part in this research, such as disclosing suicidal ideation, were discussed with the author's academic and field supervisors in advance of data collection, and strategies for managing these were agreed. Although this was considered a low risk as participants were all currently working in Child Abuse Teams where they receive regular clinical supervision, it is acknowledged that people may, on occasion, volunteer for such studies as a means of getting help for personal difficulties (Barker, Pistrang & Elliott, 2002).

Prior to commencing the interview, procedural considerations were clarified with each participant in order that they were fully informed of the research process.

- The purpose of the study.
- How interview recordings and transcripts would be managed and presentation of material within this thesis.
- How confidentiality would be ensured.
- The opportunity to ask further questions.

This study was informed by the guidelines set out in the British Psychological Society Code of Conduct, Ethical Principles and Guidelines (British Psychological Society, 2000).

3 Results

The final sample of ten participants comprised 9 female therapists. Participants were selected from each of the three Child Sexual Abuse Teams (Team 1= 4 participants; Team 2 = 3 participants; Team 3 = 3 participants). Participants' length of experience in working with children who have been sexually abused ranged from 8 months to 20 years. Three participants had less than 3 years experience. The remaining participants had at least 7 years experience of child sexual abuse work. The interviews ranged in length from 59 minutes to 1 hour and 55 minutes.

Further demographic information about the participants is provided in Table 3.1.

	Number
Job/Professional training	
Nurse Therapist	**3**
Clinical Psychologist	**3**
Social Worker/ Mental Health Practitioner	**3**
Occupational Therapist	**1**
Length of experience working with sexually abused children	
Mean (years)	**8.6 years**
Range	**8 months – 20 yrs**
Number of child sexual abuse cases seen per month	
Mean	**10**
Range	**2 – 20**
Number of participants in a part-time abuse post	**9**
Number of participants currently in a relationship	**6**
Number of participants who have children	**4**

Table 3.1: Demographic details of participants

3.1 Descriptive results

3.1.1 Overview of categories

Based on the interview material, two core categories emerged. Six other main categories also emerged in the interviews. An overview of these categories is given below (Figure 1).

Although not the emphasis of the present study, a summary of the proportion of each interview which was taken up by each category (core and other main) is provided in Appendix II.

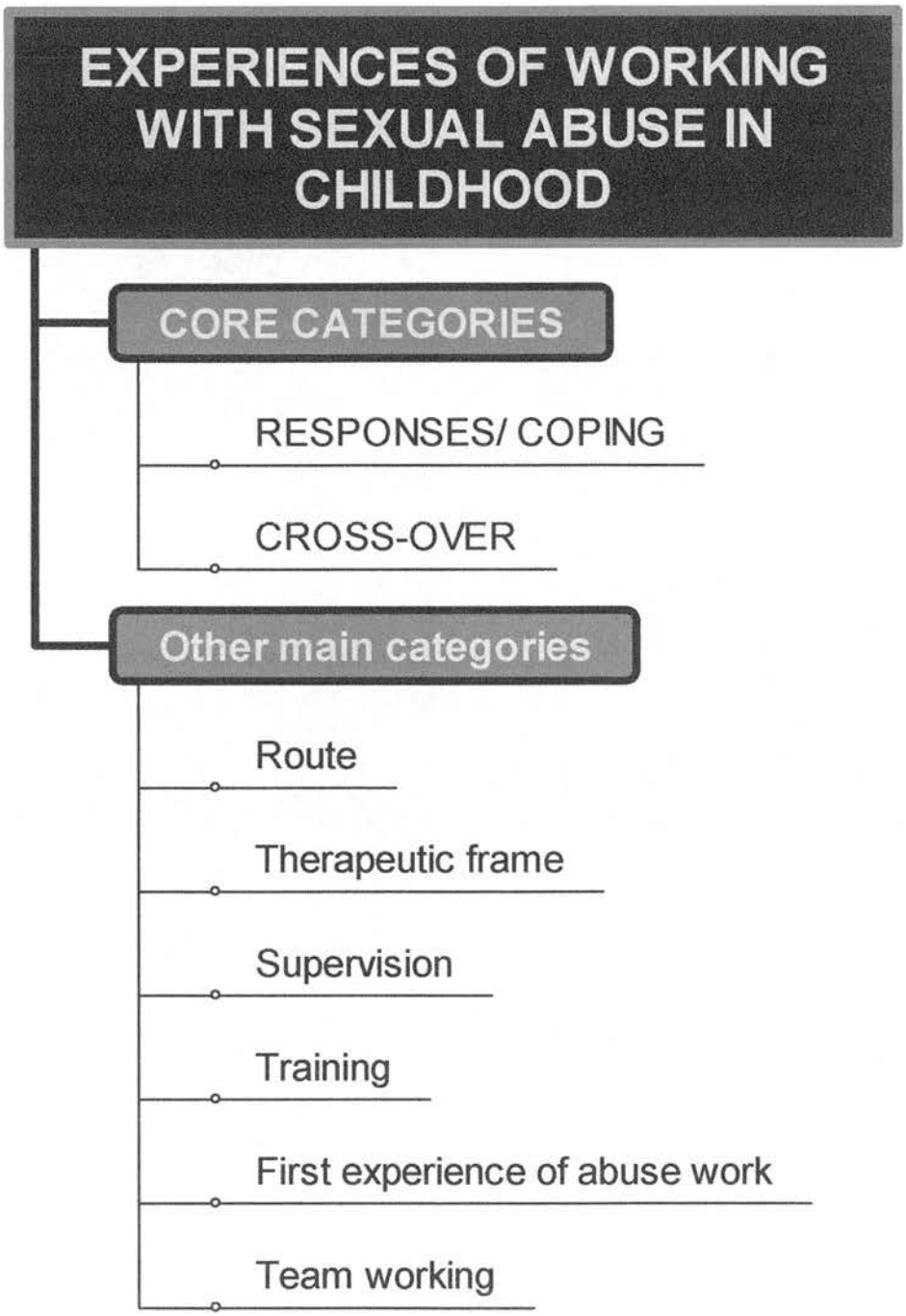

Figure 1: Core categories and other main categories related to experiences of working with sexual abuse in childhood

A description of the core and main categories will be provided in the first part of the results section with reference to direct quotes from individual transcripts. In the second part, the findings will be considered in relation to hypothesised processes of traumatisation.

3.1.2 Core categories

3.1.2.1 Responses/ coping

Participants' responses to working with childhood sexual abuse and ways of coping with those were subsumed into nine sub-categories. These are outlined in Figure 2.

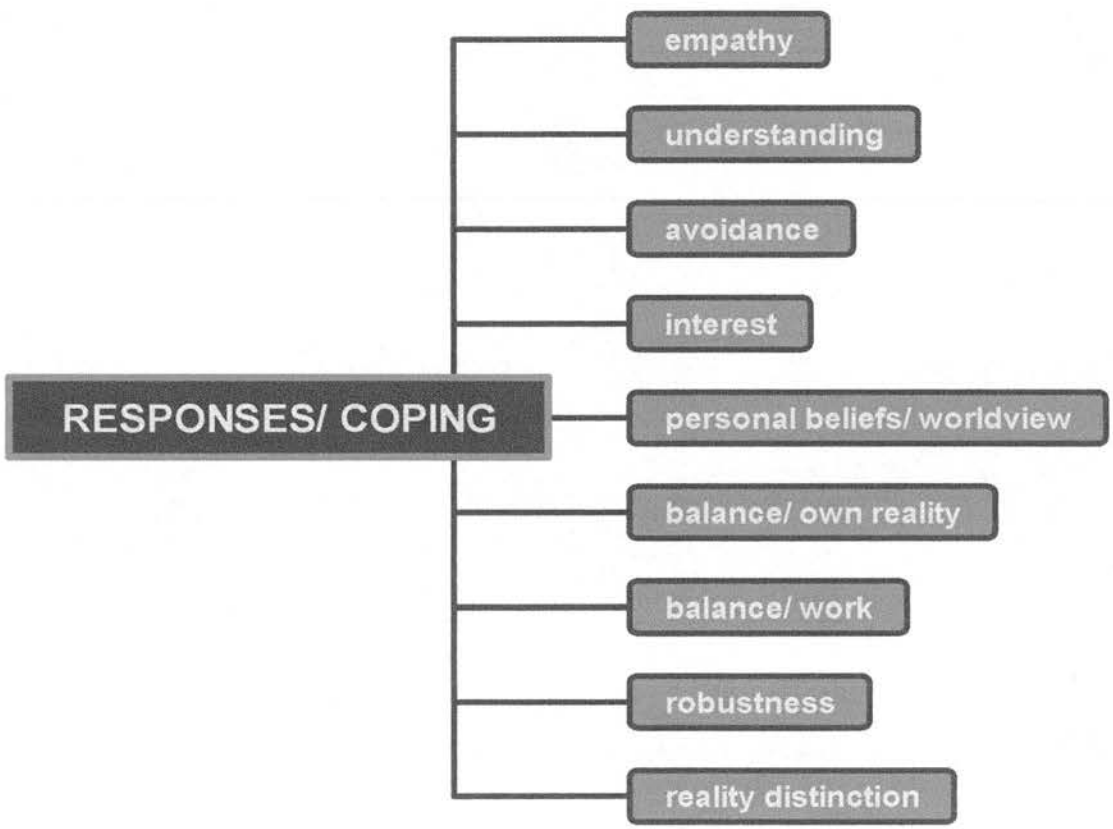

Figure 2: Overview of subcategories for core category – Responses/ Coping

EMPATHY

This category relates to the empathic process as experienced in therapeutic work with clients, that is, the therapist's experience of emotion as part of therapeutic work.

There are a number of aspects to this category. One can be characterised as a fear of experiencing emotion. This fear appears to stem from the perceived potential for having powerful emotional reactions in response to clinical material. The need to protect oneself from being emotionally overwhelmed is emphasised.

having powerful emotional reactions in response to clinical material. The need to protect oneself from being emotionally overwhelmed is emphasised.

"I think it's really easy . {{1 sec}} I think a lot of these cases for people's boundaries to get mixed up (right) as well (uh-huh) and ehm we've all been like that I suppose, feeling we can rescue people and save them" Participant 7

Another aspect of the empathic process is characterised as the importance of experiencing emotion within therapeutic work as a means of understanding the client's emotional processes. Indeed for some, such empathic connection is regarded as a necessary condition for therapeutic work.

"and . . {{2 sec}} how you need to try and feel that sometimes you know (mm-hm) to actually stay in touch with just where some of these people we see are (mm-hm) you know" Participant 6

Among the present participants there appeared to be a struggle for some as to how to maintain this empathic stance, in light of the potential for being overwhelmed but also the perceived need to be sensitive to their emotional responses. This struggle was characterised in terms of needing to find a balance between numbness and rawness. Another aspect of this category would seem to be that protecting their empathic stance involves an acceptance that the work will have, and does have, an emotional impact on them.

"how do you, how have we, if we, presuming that we have, (mm) ehm got the balance between being kind of raw and open enough (mm-hm) that you're still tuned in to what people are bringing and what children are bringing, ehm, but also detached enough not to be overwhelmed (mm-hm) ehm and that kind of without being too numb you know (mm-hm) so that you don't feel that ehm" Participant 6

"I think it's proper that people get upset (ok) you know (uh-huh) when you hear some of these accounts I think if you're not touched in some way, and that's not just for CSA work you know, some of the young people coming here have had terrible lives

(mm-hm) ehm so if you don't allow yourself to be touched by that then you miss something really" Participant 1

The narratives of the participants also suggest that, at times, their empathic stance is threatened as they identify with the experiences of their clients, an experience which is often emotionally distressing. The emotional involvement in these experiences is reflected in the expressive use of first person in the following extract, as compared to previous extracts which demonstrate a more detached perspective.

"so actually to have done it and she did it really well and I just felt really pleased for her and sort of proud of her (mm-hm) sort of thinking you know she's done well and everything but I was really upset you know (right) when I came in here you know (yeah) and I spoke to two of my colleagues and I was crying my eyes out (uh-huh) you know and eh I just said, just 'cause I like her, it's just so terrible imagine doing that to her you know (right) and everything you know" Participant 7

A final aspect of the empathic process is a concern about the potential to lose empathy and become hardened in response to abuse narratives.

"I just hope I don't all of a sudden one day turn round and think oh my god I'm so, such a hard bitch now (right) that I never realised it (uh-huh) that I don't blink an eye when someone talks about abuse (ok) and that I suppose it's just about I'll have to watch that (mm-hm) but I don't know (mm-hm) I don't know if, how it happens (ok) or if it happens" Participant 5

UNDERSTANDING

This category considers the role of understanding in response to abuse work. One facet of this is that the possession of knowledge is seen as important. This seems to relate to the quality of knowing what to do in clinical work which provides a feeling of competence. Another aspect of one's knowledge is the acceptance that there are limits to this. This aspect includes the acceptance that learning is an on-going part of

the role, and that acquiring knowledge or competence also depends on clinical experience.

"validating it (mm) without assuming that we actually know what's best or how you should feel or how you shouldn't feel (right) ehm until you know a bit more of the meaning of that experience for the young person" Participant 1

Another facet of this category can be characterised as rationalising. Having a rational understanding appears to allow some therapists to accept the limits of their role.

"working in a therapeutic team we're about that {{makes a hand gesture to show how small}} in somebody's life, a tiny part of somebody's life. I I don't have, I think we can help and I think we can make a difference (mm-hm) but I don't think we are the be all and end all (right) I have to say I don't, I think it's a whole lot, much bigger picture you know" Participant 7

Four participants described another aspect of understanding. They spoke of the importance to them of focusing on their client's survival, that is, the strength of human beings to survive traumatic experiences. Their narratives suggest that this understanding is sustaining for them because it provides a counter-balance to the damaging aspects of human nature to which they are exposed in their work.

"whilst humans do unspeakably horrendous things to each other at times, humans have the capacity for some amazing change (mm-hm) and growth (right) and things and so it's the, it's being able to hold both parts (mm-hm) that's that that sort of spectrum (mm-hm) really (right) ehm I mean I've seen incredible courage in some young people that I suppose sustains me (mm-hm) as much as the the difficult things" Participant 4

AVOIDANCE

This category encompasses participants' responses to, or means of coping with their therapeutic work with abused clients which imply avoidance of their own emotional responses. Three aspects of this were evident.

These were distraction,

"sometimes what I do need is to go and have a cup of tea and a laugh and a ehm and wind down (mm-hm)" Participant 4

rationalising about possible emotional reactions,

" sometimes I'll be kind of sad but they don't stay a- you know 'cause it always sounds a bit glib but it's like, it's not mine, you know, it's theirs (mm-hm) you know" Participant 6

and the suggestion of a dissociative process, that is splitting-off of emotional experience.

"Ehm I think it's it's kind of about when when people are telling you about extremely distressing things really (mm-hm) I think I think have to kind of ehm obviously listen to that and believe that and and empathise with them as much as I can but I need some place to put that when I leave kind of stuff I can't carry that stuff around with me I need to kind of, I need to put it somewhere" Participant 8

INTEREST

In this category, aspects of participants' work which appear to sustain their interest in it were described. One facet of this is having an intellectual interest in abuse work. This may be in addition to an interest in working with children. Such interest seems to be sustaining in that there are seen to be continued opportunities to learn within the work.

"and I think this is the first job where I still felt year after year that there's still things to learn about how to do the work or about myself (right) or about other people and because I've kept doing courses" Participant 10

The other facet of this category was presented by four participants who regard themselves as being privileged to be able to help children and young people who have been abused. This view seems to have a protective function for these therapists in that it provides a counter-balance to the distressing aspects of the work

"I've had and it almost feels like the privilege 'cause I think it is a privilege to work with with young people who've come through those horrendous experiences and actually come through the other side and been able to to move on and you know deal with ho- mm- massively painful issues (mm-hm) massively distressing difficult ehm challenges and come through that, that feels like a huge privilege as well" Participant 4

Despite the sustaining aspects of being interested in this area of work, potential difficulties associated with this were highlighted by one participant.

"You know I have just tried to sit down and talk with people about about it all but you still quite, if they're interested, they're interested really (mm-hm) you know but I don't think, they don't always realise that it can be pretty horrible as well you know (right) I think they just think it's interesting you know (yeah) or something (uh-huh) you know" Participant 7

PERSONAL BELIEFS/ WORLDVIEW

The reports of participants in this study demonstrate that working with children and young people who have been abused has impacted upon their own beliefs or views of the world. A number of aspects were evident in this category. One aspect is an awareness of the potential for the work to negatively influence personal beliefs. Another aspect can be characterised as the work having an impact on personal beliefs.

The range of participants' beliefs which were affected included those relating to parenting, trust in other people, and institutions such as the legal system.

" that has made a big impact (uh-huh) and I'm aware that still now (right) my heart falls when I here young people saying they're going to court (right) and ehm I suppose I have no sense of there there being any sort of justice really (right)"
Participant 4

Another aspect of the impact on personal beliefs or worldview is that in response to their work with victims of abuse, some participants are motivated to influence the views or beliefs of others. These narratives reveal the need to enlighten others about the impact of abuse. Such need for societal influence can extend to active campaigning, which included changing others' beliefs and working to improve understanding of abuse beyond the immediate work place.

"there is stuff that folk need to know (yeah) folk need to know stuff (uh-huh) and and unless people like us actually bear witness a bit then nothing is really going to change either (right) so it is about how we do that (uh-huh) you know about how we . . {{2 sec}} make su-, 'cause people don't have a way of finding out stuff and unless you you know whether that's about CSA or whether that's about (mm-hm) kind of the impact of poverty that so- you know it just you know unless people who know about it tell other people about it (mm-hm) then people won't know so . . {{2 sec}} so that's that's kind of important you know to kind of do that bit and I think it'd be quite easy to not do that"
Participant 6

BALANCE/ OWN REALITY

The concept of balance arose in several interviews. There were two main aspects to this. One related to a perceived need for balance within clinical work and the other, to balance in life outside of work.

The category of balance/ own reality incorporates reflections on the importance of having stability in one's personal life. In addition this category includes aspects which

suggest that this work impacts upon participants' own reality. This impact upon own reality had two qualities. One was characterised as intrusive experiences, including thoughts, dreams or images which seemed to occur particularly after bearing witness to distressing details of abuse.

"and I remember going home that night just with this image full in my head"
Participant 4

The other aspect was that of identification which included identifying oneself or another person with an abusive experience.

"I'd been on a conference and one of the case studies had a kind of little kid (mm-hm) and the people I was staying with while I was at the conference had a two year old and it's more about, sometimes really hitting home, it's kind of that size of a little person y- you know (mm-hm) ehm and just the kind of . . . {{3 sec}} what's the word I can't think of the right words, just the kind of kind of incredulity as well that you know that of of that kind of harm to that kind of a little person"
Participant 6

BALANCE/ WORK

Balance was also discussed in relation to the clinical workload of abuse cases. The importance of caseload balance appears to be linked to the emotional impact of casework. Three main facets were apparent in this category. These were concerned with the quantity of cases held, the quality of these cases and perceptions of accumulated casework.

Participants feel that a small abuse caseload is manageable, in that it is not emotionally overwhelming. Reference was also made to the manner in which cases are acquired, such that gradual up-take of cases is seen as preferable again because this is less overwhelming.

"Yeah, yeah it is actually, it's the number and the time and ehm . . {{2 sec}}... and not actually thinking specifically about what the cases are (right) and (mm-hm) and how difficult they are yeah (right) that's interesting actually but I haven't really been thinking about it in that way (right) it is more just about the number"

Participant 3

"so it was like a gradual increase (uh-huh) of of my time here really which I think is quite a good way to do it at first 'cause I think if I had started full-time here I think it might have been really overwhelming (ok) for me I think" Participant 8

There is an emphasis on having a balance of cases, specifically that a therapist should not carry too many cases of severe abuse. Severe abuse in this sample was characterised as prolonged, usually intra-familial abuse. These cases are regarded as placing greater emotional demands on the therapist. Working with less severe cases is also associated with feeling competent and effective as a therapist which is another aspect regarded as enabling therapists to continue with the work. Thus having a balance of severe and less severe cases is seen as emotionally sustaining for the therapist

"But I think even in terms of csa (uh-huh) you know not having a really ehm . . {{2 sec}} you know people that have been very severely abused (right) you know by a father or a father figure (uh-huh) with a mother that's, mother doesn't believe them, doesn't support them (right) and it's all quite dire (yeah) you know ehm. I think to have a balance between some . . {{2 sec}} people that seem to have been less severely affected, less severely abused (right) you know, less adversely affected (mm-hm) you know, it needs a balance of all of that I think quite (right) I think that's good at maintaining them to work a bit longer as well (right) and not feel too overwhelmed"

Participant 7

Nine of the ten participants worked part-time in other capacities doing non-abuse work. The importance of these other roles was emphasised. There were two aspects to this. One is that this other role gives perspective to abuse work, that is, by working with less damaged individuals one sees a range of difficulties. The other is that having another role provides relief from the difficulties of working with abuse cases.

Another aspect of managing a split post acknowledged by these participants is that this can be stressful and pressurised.

"Other times the work in the CSA team can be really heavy and really difficult (right) and it actually feels that some of the eh group work that I've been involved in in you know at times in my work or the supervision I'm doing with with staff or something like that feels much lighter and much more ehm offers a kind of counter-balance to that (right) heaviness and difficulty and ehm stickiness that that might be in the CSA work (mm-hm) so I really do I like that balance" Participant 4

The final aspect of this category related to perceptions of 'burnout' or the possible impact of accumulated experience in working with sexual abuse. Some expressed doubt about the possible impact of prolonged work in the area.

"I didn't feel any sense of you know just it being too much (right) to work with CSA all the time (right) yeah? (mm-hm) ehm . . . {{3 sec}} now I, I haven't done that indefinitely so you know I don't you know I'm not talking from a position of having done that for five six you know (sure) years" Participant 6

ROBUSTNESS

This category is concerned with participants' capacity to deal with the emotional impact of abuse work. Aspects of robustness were evident in six of the interviews. Two qualities were apparent within this category. In one, participant narratives showed a quality of emotional distance or control in relation to their experiences of the work.

" I don't feel you know when someone comes up with something I I don't feel shocked and I don't feel ehm anything like oh you know this is too hard I can't deal with it (right) you know so it, it's probably a coping mechanism {{both laugh}} to be emotionally a little bit more distanced (mm-hm) but ehm at the same time still be really empathic and understanding." Participant 10

"and the worrying thing is I don't think it does affect me quite as much as it did you know (right) I think I have become harder or (ok) de-sensitised (yeah) or you know but

And how, do you have a sense of how that's happened?

Just over time I think (uh-huh) hearing more and more stuff (yeah) ehm like I say I don't think I'm quite as surprised now (right) you know (yeah) ehm . and . . {{2 sec}} yeah I think it's just that, I'd more expect it to be a lot more to be said, than (right) than I, than you're ever told in the referral letter or what (right) you first hear about, you know (mm-hm) ehm . . {{2 sec}} so I think you know, I'm a bit more aware that a-, there might be a lot more to come" Participant 7

The other quality was that of a robustness which appears almost characteristic, and could be described as 'heroic'.

"I guess it was a, you know, oh that's ok I can live in a world where that happens I just need to know (uh-huh) you know (yes) I need to know so that I can think about how we work with that" Participant 6

REALITY DISTINCTION

The category of reality distinction encompasses the ways in which participants make sense of the experience of working with abuse victims as a particular client group. There were two distinct aspects to this. One is to regard abuse as exceptional, a phenomenon affecting a small, distinct proportion of the population. These narratives suggest that there is a potential to lose that perspective, consequently participants emphasise the need to remind themselves that their experience is not 'normal'.

"other times I'll think actually, you know, that's much more about your experience and I have to keep this in context. Yes, I see large numbers of people who've been sexually abused but that's that's not, you know, that's, that's a very ehm ehm particular sample {{laughs slightly}} (mm-hm) that you're that you're looking at and it's not really like that in the whole world" Participant 4

In contrast to this view, there is the perspective that traumatic experiences are commonplace. With this, it seems the boundary between what might be heard within work, and reactions to abuse accounts in the world outside, has become lost.

"not that I routinely bring it up at dinner parties you know but (right, mm) you know I'm sort of, but I'm constantly surprised at ehm how unlistenable to other people find it" Participant 6

3.1.2.2 Cross-over

The second core category was that of cross-over experiences. This term refers to a number of responses which participants describe occurring in their lives outside of work that they relate to their experiences within therapeutic abuse work. These were subsumed into nine subcategories. An overview of these is provided in Figure 3.

Figure 3: Overview of subcategories for core category – Cross-over.

PARENTING/ OTHER CHILDREN

This category encompasses aspects of participants' experiences with children outside work which have been affected by their work with abused children. This includes being a parent, and relationships with other children such as friends or family members. Four of the ten participants in this sample are parents, nonetheless the remainder spoke of experiences in relation to other children they know.

members. Four of the ten participants in this sample are parents, nonetheless the remainder spoke of experiences in relation to other children they know.

One aspect of this is that fear of abuse to their own, or other children, is common, resulting in a strong desire to protect them from potentially dangerous situations or to know in detail about their experiences. Fears for children's safety related to a perception of the world as a bad place, particularly for children, with abuse regarded as beyond a parent's control. The potential to become over-protective of children was endorsed by all participants however the extent to which they act upon this varied.

" you know I think there's a kind of dawning on you that actually the world can be a really dangerous place (right) for kids (mm) and that no matter what you've given your kids in terms of confidence or ehm you know self-esteem and ideas about safety and all the rest of it (mm) things can happen" Participant 1

Another aspect of this category is gaining relief from this fear. This appears to happen in two ways. One is seeing evidence of 'normal' behaviour in their own or other children, which suggests that they are not being abused. The other relates to the age of the children. Three of the four parents in this sample explained that their children were now adults. This was felt to be significant, in that they did not experience the same fears for their children.

"Yeah I can see that, that that would happen (right) because you could become quite paranoid about family and friends (mm-hm) yeah, it makes sense. Yeah I just think it was perhaps different for me (right) because I wasn't in that position anymore" Participant 9

In contrast, identifying the experiences of clients with children in one's own life was another aspect of this category which was apparent in some narratives. This seems to place a heightened responsibility on practitioners to understand or protect children out of work.

"I suppose just that worry when I think of my niece I think, you know, hoping that it would never (mm-hm) be something that would happen to her (mm-hm) and how that, how that could really impact on her life" Participant 5

A final aspect of this category is that having contact with children outside of work can also be a corrective experience for therapists, by providing positive models of children who have not experienced trauma or abuse.

SELF CONTAINMENT

This category refers to the capacity to manage and hold one's emotional reactions both in work and outside. There are several different facets to this. One is an acknowledgement that the emotional impact of this work is, at times, difficult to contain and may need to be shared with others. Being able to access team support out of hours is one response to this.

Another facet of this is that experiencing distress in one's personal life threatens this capacity because coping with personal difficulties is an additional demand on top of the emotional demands of work. Being personally distressed can also impact upon therapeutic work by increasing identification with clients. Being in distress oneself can also make others' distress burdensome or unbearable, because there is a feeling that one may be emotionally overwhelmed. Indeed from participant narratives, it would seem that, working in this field, the amount of personal distress which can be tolerated (i.e. without impinging on therapeutic work) is low. There is a perceived need to protect oneself from personal distress to preserve the capacity for self-containment.

"I think I was kind of trying to support a lot of people (right, uh-huh) which made it difficult to do the work as well (right, mm-hm) kind of feeling like you know you you

were being relied on at work and then you were being relied on (right) out of work as well (uh-huh) by your family (uh-huh) and and and not really being able to get away from it (ok) ehm and also just because I was, at that point, I was really really busy and ehm . . {{2 sec}} I think I'd probably taken on a bit too much work actually (right, mm-hm) you know cross the board, because I was just in different places all the time ehm . . {{2 sec}} I I just started to struggle" Participant 3

INTRUSIONS

Another distinct category of responses to abuse work which crossed over into life outside was that of intrusive experiences. There are two aspects to this; one can be characterised as intrusions in participants' inner world. The other, characterised as intrusions in sexual experience. The range of inner world intrusions included intrusive thoughts, dreams and mental images. These may relate to a particular traumatic account to which the therapist has been exposed, or be more generalised, that is occurring without an apparent trigger.

"I was also aware that after that I was much more anxious ehm for about probably for about the period of a month when I was out on my own walking around at night (god, right, uh-huh) I was much more aware of ehm . . {{2 sec}} I suppose being vulnerable" Participant 4

"I might be at home and all of a sudden I start re-thinking about what someone said to me (uh-huh, right) and eh images come come in my head about abuse (mm-hm) and things" Participant 5

Intrusions into sexual relationships seem to occur when a therapist identifies with a client's reported experiences, which then impacts on their sensuality. One participant had experience of this. Those who did not experience intrusions in their sexual life emphasised that this was because they did not identify their sexual experience with the accounts of sexual abuse to which they are exposed at work. Others participants who discussed this aspect did so in a detached way, acknowledging the possibility for such intrusive experience, without alluding to personal experience.

"I remember you know being with my ehm boyfriend you know my partner that night thinking oh god imagine if that happened to me I wonder what we'd be like you know just (right) I just (uh-huh) I did feel myself thinking about it and I didn't feel like having sex that night you know (right) I it was that sort of thing I just didn't feel that ehm, that I felt I wanted, like I wanted to do that" Participant 7

PERSONAL BELIEFS/ WORLDVIEW

The impact of this work on personal beliefs or views of the world was both implicit in participant's narratives and explicitly discussed by them. The aspects of this category include seeing abuse as exceptional, seeing abuse as pervasive and having a view of the world as a bad place.

"I think you can end up with a very skewed view of life as well (right) you know I think it does impact on maybe how people feel outside" Participant 7

The view that abuse is pervasive was evident in participants' reactions to outside experiences.

"I suppose things like you know if I go to a swimming pool and (mm-hm) there's single men in the swimming pool that kind of thing (mm-hm) ehm and there's a sense as well that . . {{2 sec}} they're not all necessarily abusers, not all single men in pools are abusers as well (right, uh-huh) and I think I I sometimes think for males you know as well and I s- females as well it's about . . {{2 sec}} them having to keep themselves safe as well so they're not in a situation that they're prone to . . {{2 sec}} allegation" Participant 5

In contrast, other participants hold the view that abuse is exceptional thus differentiating their potentially skewed view of the world from actuality.

"suppose I do make sense of it a bit in in terms of . . {{2 sec}} you know I'm working with this every week (mm-hm) and I'm thinking about it (right) and I'm much more aware of it maybe, you know (right) sexual abuse, and (uh-huh) and the kind of risky positions that kids get left in sometimes (right) ehm (right) you know and that actually I need to remember that that my nieces are actually very well looked after" Participant 3

Rather than focusing specifically on abuse, a final aspect of this category is to see the world as a dangerous place, particularly for children. A loss of innocence, or naivety, about the world was described, which colours perceptions of people or situations that others might construe as harmless. This is related to repeatedly hearing about abuse and/ or violence at work.

"but there is something about I don't accept superficial appearances now that ehm I suppose I'm much more likely to think well is that really how it is (right) and that'd be lovely if it was really like that but actually you know sometimes it's not"
Participant 4

TRUST IN OTHERS

Within this category are contained examples of altered experiences of trust in other people. These were apparent in seven of the interviews. There were three main qualities to this category. One indicates a general wariness of other people's intentions, usually not close friends or family. Another quality is abuse fears pervading even trusted relationships. A final quality is the perception of others' trust being altered, in terms of them questioning a participant's motivation or capacity to work in this field

"so you kind of think right you get a bit kind of suspicious of other people (uh-huh) and things as well and you know that that abusers are not just dirty old men in in plastic macks and stuff you know they could be folk who are dead nice and who're charming and and come across as dead nice and and that kind of thought you know is very much it's not, but there's sometimes that it kind of can, can be present quite a lot in my head" Participant 8

"It's finding that balance really (yeah) you know/and how/and reminding people that you know it's not all stranger rapes you know" Participant 7

PROFESSIONAL ROLE OUT OF WORK

This category is about the experiences of being identified as a professional who works with victims of abuse outside of work. In one aspect, some participants experience a sense of responsibility to represent or advocate for victims of abuse in non-work setting. For others there is a different aspect, that of limiting their involvement in abuse-related issues out of work.

"I can remember being at a dinner party where people were talking about how ehm about recovered memory syndrome (right) thinking I really don't want to be doing this you know and and yet thinking should I share? Should I share my my experience and educate these people because they are just being manipulated by the media ehm and by a a number of people who's best interest this is ehm or do I or do I just allow this to be a nice dinner party?" Participant 4

"I wouldn't offer myself (mm-hm) in any kind of way as as as anything for them, as a support or anything" Participant 1

THREATS TO THERAPEUTIC FRAME

Circumstances under which therapeutic boundaries are threatened due to a therapist's personal distress are subsumed within this category. These included times when a participant's personal circumstances were out of balance due to ill health or relationship difficulties. The threat to the therapeutic boundary relates to the impact of their personal difficulties on the empathic process. Aspects of this included feeling less competent, over-identifying with the emotional experiences of clients, feeling overwhelmed by one's empathic response and being emotionally unavailable to clients.

"and that can feel really difficult if you're not able to detach from that and at times when I've been feeling a bit kind of ehm fragile in myself (uh-huh) then I've had to work very hard at being able to separate me as a person and in, you know, living my own life outside of the clinic and ehm me as a therapist working with these young people (right)." Participant 4

"I think it made me more kind of disorganised in the sessions I think probably a bit more detached (right) so I maybe kind of reverted back to my defence (uh-huh) I mean not not in the same way as before but I I wasn't able to, I wasn't able to listen (mm-hm) and understand and the kids picked up on that and I knew that they were picking up on it (right) and that was really hard" Participant 3

IDENTIFICATION WITH ABUSE EXPERIENCE

This category relates to participants' identification with the abusive experiences of their clients. One facet of this is identifying with the actual experience of clients through direct personal experience. Another facet is that, in hearing abuse narratives, participants identify with affective aspects of their client's experience and relate that to personal experiences where they have felt similarly. These participants acknowledge that such personal experiences may influence their empathic responses to clients.

"I think (mm-hm) you know even though that hadn't actually happened to me (mm-hm) I could identify with some of the feelings (mm-hm) and issues that (mm-hm) that she brought up, you know, it didn't seem (yeah) completely different from my experience you know (mm-hm) from my experiences of life you know (mm-hm) sort of thing" Participant 7

"my daughter had been ehm sexually ehm abused (gosh, right) which was really an awful incident and I, I remember I was so angry, I was so furious you know (mm-hm) ehm it was, it was really awful, ehm I don't know maybe in a way that's helped me to understand ehm parents and their reactions, which is sometimes not helpful for children (mm) can make things worse you know but ehm I think I I I can understand where they're coming from" Participant 9

INTIMATE RELATIONSHIPS

Three participants talked about the impact of this work on their relationships with their partners. The qualities of this category include the need to acknowledge displaced emotions from work which might impinge on the relationship. Another quality is that of accepting the constraints of client confidentiality which restricts what

one can talk about with a partner. Another aspect of this category is that a partner should be protected from distressing details or finds such details difficult to hear.

"you have to contain yourself 'cause you can't go home and talk to your partner about it" Participant 1

"if I realise I'm doing it then I'll just kind of acknowledge that I'm a bit grumpy and actually and I'll talk about why it is (right) generally (right, uh-huh) ehm. . . {3 sec}} and that seems ok I think (right) you know 'cause I think the thing is I do recognise it, it's not that I don't recognise it (mm-hm) and it's not that I attribute my grumpiness to something that he's done" Participant 3

COPING

A final category encompassed the means by which participants cope with their experiences of abuse work. Aspects of this include activities which take participants away from negative emotional experiences associated with work, another aspect involves actively addressing emotional issues, while the remaining aspects of coping suggest more cognitive approaches.

Having a healthy and varied lifestyle is emphasised. There is a self-protective quality to this lifestyle approach in that it is seen to maintain emotional strength and ameliorate against the emotionally draining aspects of the work. It is for this reason that it is regarded by some as obligatory. Stretching oneself in activities or roles other than that of being a therapist is also seen as beneficial for the same reasons.

"you also have a a duty to keep yourself healthy and (mm-hm) ehm and to have other, you know, to have lots of different things in your life" Participant 1

Two other approaches to coping which were asserted in terms of necessity were having light relief and/ or avoiding abuse-related material outside work. Light relief encompassed having fun and/ or relaxation and activities which appear to offer more

spiritual sustenance such as enjoying the landscape. Again these activities are seen to help participants cope by providing a counter-balance to the 'dark' or distressing aspects of their work.

"I remember ehm that weekend going for you know, really saying to my partner I want to go for a walk. I want to be somewhere beautiful I want to see eh I want to see goodness (mm) and ehm whatever and I remember going for a walk feeling that whole sense of of letting go of what had happened (right, uh-huh) and taking in the beauty around me" Participant 4

Personal therapy or supervision are also identified as valuable, by providing a safe space in which to address emotional issues including those which overlap with work and increasing self-awareness.

"I think it has, it's helped me an awful lot in terms of understanding myself and understanding the work that I'm doing (mm-hm) and the way I think about it (mm) . . . . . {{5 sec}} and I'm not sure how I would be doing things at the moment if I wasn't doing that" Participant 3

Rationalising about work and its personal impact is another means of coping.

"I think that's one of the things that I've learned is imperative is to be self-reflective and to stop and think why am I not sleeping, why is my skin all broken out, why am I doing this that and the other and what's this about and what can I change (mm-hm) and have to change the things I can change and the things that I can't change I have to let go because I think if you're not self-reflective then I think you would just burn out here, (mm) one would burnout because you know without looking at it, it would just eat away at you" Participant 10

For some coping with difficulties appeared to be somewhat characteristic rather than deliberate, suggesting heroism or personal resilience.

"remember very clearly that time when I felt as if I can't carry on doing this work, but I I was so, ehm I was very fond of my clients then, it was lovely wonderful people (right) and I, there was just no way that I could just walk away and not do (right) something about it you know, so after having felt devastated {{laughs}} I think I just realised, well I just have to get in there" Participant 9

3.1.3 Other main categories

An overview of each main category and descriptors is provided in Appendices III-VII.

ROUTE

As the opening question, all participants were asked to talk about how they got into working with children and young people who had been sexually abused. All references to participants' route into abuse work fell into four aspects of this category, although many participants endorsed more than one of these.

The most common aspect to emerge in this category was characterised as the route into abuse work being an unplanned event. Seven of the ten participants' explanations of their route into the work fell into this category.

This unintentional entrance into working in a child sexual abuse team was explained in various ways, ranging from luck or an accident, through the view that it was opportunistic, to the suggestion that the motives were unconscious. Other explanations in this aspect were that participants described their appointment as being primarily influenced by other peoples' perceptions of their capability or, due to other peoples' need.

"so it was just about, I don't know, if I'd been given a placement that was really focused on drug and alcohol maybe that would have been then (right) something I would have followed through and it's just I think it's been about opportunities (right) I had opportunities then working with adolescent mental health (right, yeah) and then CSA and then the opportunity came up here" Participant 5

The remaining aspects focused on professional competence, intellectual interest and knowledge.

Competence, based on previous experience of trauma work, and the belief that one can make a difference to the lives of young abuse victims were positive influences on the route to this work. In contrast, previous difficult experiences of abuse work, or a lack of experience in this work were associated with uncertainty about the emotional impact of working in it, although this did not prevent people from taking the job.

"Oh just that horror you know (mm-hm) sort of thing I knew it wouldn't be ehm . . {{2 sec}} it's hard now 'cause I know it now you know (yeah, of course) but I think back then (uh-huh) ehm the girls I knew were par- were particularly, were very disturbed (mm-hm) and they'd hurt themselves and I just thought it seemed like a very high, high risk work you know (mm) like it ehm, not high risk work but like I I knew it would be quite hard being close to those girls you know (mm-hm) and work with them all the time" Participant 7

Aspects of interest which motivated participants to work in this area included an interest in general trauma work, an interest in, or enjoyment of working with children, and interest in working with a particular therapeutic model, often a psychodynamic approach. No participant expressed a specific interest in childhood sexual abuse as a form of trauma.

"suppose what I saw in this post was back to mental health, still working with children, it was a new challenge ehm it would be interesting, I'd be learning new things and it was a specialist area" Participant 10

Other rationales for coming into abuse work related to participants' desire to learn. Facets of this were that abuse work was seen as a challenge, that this was an opportunity to develop skills or become specialised in an area of work.

"I felt that I would like . . {{2 sec}} the opportunity to do something a bit more challenging and I saw this type of work and working with these kids you know the sort of more play therapy psychodynamic approach and working with kids who'd been through ehm you know that kind of trauma as being more challenging I guess (mm)

ehm and more interesting and more where I was perhaps you know developing my own therapeutic skills and stuff (right) ehm so I guess that's what appealed about this"
Participant 2

THERAPEUTIC FRAME

Aspects of working within a therapeutic frame are included in this category. These include positive and negative aspects of engagement in therapy with abused clients, and the limits of therapeutic work.

Engagement in therapy can be difficult. One facet of this relates to particular families or individuals being hard to engage with. Another facet of engagement is that the experience of abuse may impact on a client's trust in the therapist, which can feel challenging. Other difficult aspects of therapeutic engagement include feeling upset in response to a client's emotional experiences. The importance of therapeutic boundaries is emphasised in lieu of the therapist's perceived susceptibility to being emotionally caught off-guard.

"because you're entering in, because these young people have been abused within a relationship they often bring their pain and distress into the therapeutic relationship with you and so they're going to enact that, you're very often I suppose, you know, the the transference is one of of ehm you know that you are yet another adult who's going to hurt them and abuse them and that can feel really difficult if you're not able to detach from that"
Participant 4

Although therapeutic work with abused clients does not always feel rewarding, due to some of these difficulties with engagement, therapists can experience a sense of achievement when they see progress in their clients.

The limits of therapeutic work are also highlighted. One is an acceptance that clients may come with ambivalent feelings or be unable to address abuse issues directly. Other aspects of the limits of therapy are that it cannot replace a child's experience of

being with their family and that factors out with the therapeutic frame can influence a clients' progress, for better or worse.

"and I just think oh my god you know 'cause sometimes it's not always people get better you know sometimes they get worse you know (right, mm-hm) ehm and it's not necessarily through the therapeutic work it's getting worse it's that you s- you what their situations just change in some sense you know (right, mm-hm) 'specially children that have not really got an awful lot of control really"

Participant 7

SUPERVISION

Categorical data on the theme of supervision comprised two main aspects, one describing interpersonal dynamics, the other, intra-personal processes. Accounts of supervision demonstrated the importance of a supervisor acknowledging and validating the individual's distress, offering containment, reassurance or normalising the emotional distress. Supervision is regarded as a space where one can collaboratively process, or reflect on, emotionally difficult experiences. As a person to relate to, the supervisor may offer perspective or insight in this process.

Interpersonal dynamics

Important qualities of the relationship with one's supervisor which were described are that it is protective and supportive of therapists. Empathy and trust are more valued than, for instance, the supervisor's experience of working in the field of child abuse. At other times, their capacity to be directive or take action in response to the distress of the supervisee is important. That supervision is on-going and valued within the work context are qualities which therapists also appreciate.

"the main thing is the space to talk really so I need, you know, having that sort of trusting ehm . . {{2 sec}} relationship with someone that I respect (mm-hm) you know because I sometimes do need to work it through as I'm th- as I'm, you know, as it's happening (mm-hm) and ehm . . . . {{4 sec}} and it's less important that that

person has tons and tons of CSA experience (right) and more that they . . {{2 sec}} have the kind of skills really to . . {{2 sec}} to help me work it through"

Participant 6

As a place where people bring personal distress, the need for flexible supervision, in terms of frequency, and at times, immediacy, is emphasised. Through supervision one can learn about clinical practice however the present participants also highlight the importance of learning through clinical experience.

Intra-personal processes

Supervision in the context of abuse work, although rarely talked about in depth, is seen as essential, in that therapists cannot do this work without it. In difficult times supervision is often what enables therapists to continue working. Accounts of supervision illustrate that as a process it leaves the individual feeling contained because they would appear to have internalised the experiences within supervision such as the acceptance of having difficulties and the need to share these.

"So the life line I suppose was was really about feeling that I didn't have to swim about in the sea of awfulness and find my own way out, it was about somebody throwing me a rope and saying once a week you can talk to me about it"

Participant 10

Within supervision participants feel able to discuss personal issues. Nonetheless limits to this were highlighted, with varying levels of comfort about how personal one can get. Previous experience of supervision may contribute to how safe people feel in discussing personal difficulties. The capacity to benefit from supervision was also related to the individual's familiarity with it.

"'cause the other thing I suppose is is about ehm the relationship you have with your supervisor (uh-huh) ehm and I think I've been really lucky 'cause I have got a good

relationship with my supervisor and I do feel comfortable (right) talking about personal things (uh-huh) to to a point you know (yeah) ehm but again if if I didn't have that supervisor (right) how would it have been? (ok) what would have happened? (uh-huh) what might have been . . {{2 sec}} different?"
Participant 3

TRAINING

This category relates to participants' training experiences. These were often referred to as part of the participant's explanation of how they came to work with sexually abused children. Three main facets to this category were the influence of training experiences on current roles, the limits of training experiences, and that current work is a motivation to pursue further training.

For many, training experiences have been influential in terms of participants' current roles. One aspect of this is that, through training opportunities or obligatory placements, participants had experiences which sparked their interest in trauma work and/or, working with children. Another aspect was that, for some, such interests pre-existed and training experiences served to shape these interests further. Training experiences also proved to be influential in another aspect, whereby they provided a knowledge base by which participants understand their current work.

"I think the training that I undertook later on gave me a kind of a, a map to work with to plot things which helps to ehm lessen almost the emotional impact (right) of the work (uh-huh) so I think that you you do need something, some other map or strategy or plan you know that you, according to which you work." Participant 9

Participants talked of the relative merits and limits of the therapeutic approaches in which they were trained. Experiential learning experiences within, for instance, specific therapeutic training were described. The emotional demands of this were highlighted, as well as the benefits of such experience for fostering or encouraging self-awareness.

"and it's about the experiences here and it's about the trainings that I've done but I've learned now to be self-reflective and reflective about other people as well and now I have you know a bit of an idea about, about relationships and about, you know, the dynamics between people and about projections and about transference"

Participant 10

The limits of training experiences were also identified. Being 'in training' was sometimes associated with negative experiences such as perceived pressures or, feeling de-skilled, which can leave the individual feeling unprepared for "qualified" status. Theoretical knowledge alone is of limited value, and no substitute for clinical experience, which is seen as valuable and necessary in developing competence.

Other references to training were descriptive statements about how, since coming into abuse work, participants have been motivated to pursue further training.

FIRST EXPERIENCE

This category is concerned with participants' accounts of their first experience of working with victims of abuse (adults or young people). These featured in nine of the ten interviews. Participants' recollections of what happened and their affective responses to this were detailed and vivid. The emotional impact of these experiences was reflected in the highly involved narratives, and the clarity of these memories, even in some cases, of events which took place several years before. Three aspects of these first experiences were apparent – participants' counter-transference responses, their recollections of the dynamics in the relationships with these clients and their reactions at the time.

A range of affective responses were described in response to abuse material and/ or the projected emotions of the victims themselves. These included dread, fear, shock, horror, feeling overwhelmed and guilty. Some experienced intrusions into their own reality as a response to these early experiences.

"and with the younger girl I was really anxious, I was nervous of her because she was a really really angry, angry young woman (right) and she frightened me"
Participant 10

Particular dynamics of the therapeutic relationship with abused clients were also recollected. Aspects of this included feeling one's personal boundaries being challenged, struggling to contain one's affective responses and identifying with a client's emotional experience.

"seeing that there was so disturbing, you know, like I had ehm, you know, I mean I was upset I mean I cried the next morning you know after 'cause I had to just sort of hold it together fine to be with her" Participant 7

Reactions to this first experience of abuse work were quite varied. Feeling inexperienced or that one was lacking knowledge and understanding was one aspect of this. A tendency to intellectualise was also apparent, for example by rationalising about what was learned from this experience, or being concerned with society's role in perceptions of abuse. Another aspect was avoiding getting involved in abuse-focused work, or focusing on preventative work.

"it's a horrible feeling you know as a staff nurse who has a bit of experience you know, kind of used to knowing what to do in any kind of given situation, ehm you know, knowing what to do if somebody took an overdose, knowing what to do if somebody was self-harming in the bathroom, finding out what to do when someone set fire to their nightie and came running along the corridor towards me {{laughs}} but then somebody told me they'd been abused and not knowing what to do"
Participant 10

EXPERIENCES OF TEAM WORKING

Within their interviews, all the participants talked about their experiences of working within a specialist child sexual abuse team. These responses fell into two broad

categories, those describing positive relational aspects of working in the team and those which implied negative relational aspects of team working.

Positive relational aspects

Working within the team is viewed as necessary and, as part of a wider system of support that includes individual supervision, peer support can help therapists survive the work when they are struggling. Aspects of team work which contribute to this feeling of support are the immediacy of support which is available from team colleagues, their capacity to be non-judgemental, empathic and to normalise therapists' experiences. Team support also reduces therapist's sense of isolation, because of the shared interest in abuse work and the freedom to discuss abuse related material with peers. Another aspect of team support is that it can provide an objective stance on participants' work.

you know it's, it's good the, you know, people are kind of recognising that it's challenging work and . . {{ 2 sec}} you know recognising that it brings up difficult feelings for people and that ehm you know it's ok you know to air those feelings with people it's ok to seek people out to talk about things ehm . . {{2 sec}} and there's, I suppose, there's the kind of expectation there that at times it's going to be difficult and that, that's ok (right) so that support you know it's all in place Participant 2

Team support helps people to feel contained because they are able to share personal difficulties and distress related to clinical work. In the absence of such support, participants report that they are more likely to take distress home.

The mix of skill and experience within the team is generally regarded as positive. Working within the team context provides opportunities to learn from others. Being able to share knowledge and experience with others is rewarding.

Negative relational aspects

Aspects of team work which presented difficulties included feeling inexperienced compared to colleagues, fear of how others' might perceive their way of working, or feeling pressurised due to perceptions of others' competence.

"I suppose it's about seeing, seeing how other people work and how other people kind of try, do try to sometimes, try to squeeze people in and that feeling of well maybe I should be doing that (right) but not wanting to (mm-hm, ok) because actually that's what I did before (right) and ended up feeling like I had too much"

Participant 3

Other negative aspects of team work include the expression of distress in colleagues. Although this is regarded as appropriate, it can be experienced as burdensome if one feels emotionally distressed. Being concerned about how, and whether, team members show their distress are also negative aspects of the team experience.

Waiting lists and changes to the team were also discussed. The need to be aware of the waiting list was acknowledged, however this can feel like an unwanted pressure to some. Team changes, in terms of size or skill mix, were generally considered to be enriching, however negative aspects of this include feeling stressed due to having increased responsibility and altered dynamics within the team.

"working with more people and things like that . . . . {{4 sec}} which I've enjoyed 'cause it's been really good actually (ok) but ehm it has it has made the job more stressful as well (right) because you can't just think about your own clients and you know think about the person I supervise's clients ehm other folk come up to you and talk about their cases and stuff want you to do work with their parents and stuff like that so I'm kind of my role's kind of ehm increased quite a lot really (right) so my my workload has has increased quite a lot"

Participant 8

3.2 Inferential Results

In this part, consideration is given to possible dynamic processes which can be inferred from the experiences and responses of the present participants that may contribute to an understanding of their role in the hypothesised traumatisation of therapists.

Counter-transference and the process of therapeutic engagement

Therapists' emotional experiences appear to be an important aspect of their therapeutic work. That this work engenders powerful emotional responses is evident from their narratives. Anger and over-identification with the destructive and irreparable aspects of abuse were among the counter-transference reactions of the present participants. The need to allow oneself to be emotionally affected is regarded as important therapeutically, however this appears to be offset by a need to protect oneself from becoming emotionally overwhelmed. This struggle was characterised in the present study as needing to find the balance between numbness and rawness. This would seem to infer a process of either allowing oneself to experience negative affect within the therapeutic relationship, or defending against and/or dissociating from such negative affect.

Regulating emotional experiences within the therapeutic relationship would seem to relate to the category of self-containment in this study. Self-containment in many ways appears synonymous with emotion regulation in that it pertains to a capacity to manage and hold one's emotional reactions. In therapeutic abuse work, self-containment is seen as important, both for the therapist and the client. It allows a therapist to respond to their own, and the client's emotions, without becoming overwhelmed (or overwhelming the client). As this would be regarded as an essential aspect of any therapeutic relationship, how can we account for its considerable importance to the present participants? It is argued that this reflects a qualitative

difference in the strength of the transference and counter-transference experienced in therapeutic work with victims of abuse.

Furthermore, the emphasis on having a balance within clinical abuse work can also be seen as an indication of the strength of the counter-transference experienced with particular clients. Having a combination of more severe and less severe cases is seen to protect therapists from becoming emotionally overwhelmed. By implication then, these more damaged/ traumatised clients are recognised as bringing about powerful counter-transference responses in their therapists.

From a perspective of therapist development it would seem from the present study that there may be a difference in the experience of emotion within the work according to the amount of experience therapists have in working with victims of abuse. Therapists with greater experience tended to show more robustness in their responses to clinical material. Robustness describes the capacity to experience emotion, i.e. accept transference and counter-transference responses without being overwhelmed by these.

In comparison, therapists who are newer to abuse work appear to experience more of a struggle with finding the empathic balance and managing their counter-transference responses. They are aware of the importance of being emotionally responsive within therapeutic work, however fear being emotionally overwhelmed. Interestingly it was also these therapists who expressed a fear of becoming hardened or emotionally distant in response to their clients. This too would seem to reflect the strength of the transference/ counter-transference dynamic that such an extreme response is feared.

Counter-transference and personal distress

Some participants in this study emphasised the need to protect themselves from personal distress. It would seem that the importance of this relates to therapists' capacity for self containment, that is, the capacity to contain their emotional responses or not to be overwhelmed by their counter-transference. Experiencing personal distress, for example due to negative life events such as a relationship break-up, impacts on the therapist's self-containment, that is their responsiveness to counter-transference. Evidence for this was encapsulated within the category of threats to the therapeutic frame. Times when participants were personally distressed appeared to impact upon their self-containment, that is, their responsiveness to counter-transference. They described either being under-regulated, that is feeling overwhelmed or over-identifying with clients' emotional experiences, or being over-regulated that is being emotionally distant.

The emphasis on protecting oneself from personal distress was stronger among experienced therapists. They were also more likely to consciously and actively work at this. Why then might this be so important to these therapists? One explanation may be because they perceive the importance of their counter-transference to the therapeutic work, and the need to be contained for the sake of the client. However it may also suggest that they have internalised the negative emotion from their work and therefore cope with this by avoiding further negative emotion out with work.

Coping with therapeutic work – the impact on the therapist's personal life

The importance of planned avoidance

It is proposed that the category of cross-over experiences, that is the impact of this work on therapists' emotional lives, can be understood as a continuation of the powerful dynamic processes (identification, transference/ counter-transference) inherent in this therapeutic work. The importance for some, though not all, therapists of having a balanced and varied life outside of work was emphasised in this study.

This was often presented in terms of things which one needs, or has to do, to cope with the work. This suggests that in being able to live a 'normal' life outside of work, therapists feel they must work hard to restore equilibrium in their emotional lives. It seems that therapists recognise the negative emotional impact of this work and, importantly, employ coping strategies in an active and conscious manner to counter-act this negative emotion. There is clear intentionality in the use of such strategies prompted, it would seem, by a level of reflection about its relationship to work, e.g. this is something I need to do to cope with the work.

That the use of these coping strategies has such an intentional quality might also suggest that the negative emotion from work has become part of the therapists' internal experience. In this study ways of coping with the emotional impact of work outside of work imply avoidance. These include needing to see beauty in the world, avoiding abuse related material outside of work, distracting oneself from, or avoiding, negative emotion.

Again the perspective of newer therapists was slightly different in this aspect to that of more experienced therapists. The use of coping strategies among newer therapists was reported without clear and reflected intention, e.g. I do what I do, and this was not related particularly to coping with the work. In contrast, experienced therapists were more likely to espouse the need for deliberate and specific coping strategies (coping is intentional), which they see as self-protective because they allow restoration of their emotional equilibrium (coping is necessary to ameliorate the negative emotion from work). Implying that for more experienced therapists, the distress of their clients may have become part of their experience thus coping with this has also become internalised.

Having an altered view of the world also impacts upon therapists' experience of it. This too would seem to represent an internalisation of the destructive and damaging aspects of abuse, in that, responses to this are seen as deliberate and necessary. With

respect to the perceived loss of innocence described by some participants, their responses suggest that this can cause an emotional imbalance which they feel they must aim to restore. In many ways, the range of coping responses to this aspect could be seen as attempts to regain an emotional equilibrium. For some this involves seeing a counter-image of the world as a beautiful and positive place. Others gain relief by reminding themselves of the uniqueness of their experience and distinguishing that from reality. For one participant restoring equilibrium, at an extreme, seems to involve holding a generally negative view of the world and bringing the reality of abuse into life outside work, telling others about it and so on.

Projective identification and outside experience

Within the category of cross-over experiences, it is proposed that the impact on therapists' interpersonal relationships would seem to be suggestive of projective identification. This was manifest in participants' fears for the safety of children, and, for some, altered experiences within their intimate/ personal relationships.

Participants tended to ascribe these experiences to a cognitive change, that is, in their beliefs about the world, and the safety of children in particular. However, the affective quality of the impact of this suggests more than cognitive change for example, the expressed need to protect one's children from abuse or questioning the motives of previously trusted people.

It is proposed then that in therapeutic work with children who have been sexually abused, some aspect of their impaired interpersonal experience, such as fear of others or betrayed trust, is projected onto the therapist, who internalises this and subsequently projects this into their relationships with particular children, or indeed intimate partners in their life outside. It is suggested that the strength of the identification in this sample is indicative of the strong dynamics experienced in therapeutic work with children who have been abused, particularly the impact of

abuse on their relational schema and therefore what is transferred into the therapeutic relationship.

Why then would some therapists but not others experience impaired interpersonal relating as a consequence of this work? It is argued that this must reflect the interactional nature of projective identification, i.e. there is a resonance for the therapist with a particular aspect of the projected/ experienced affect which increases the power of the identification.

4 Discussion

The experiences of ten therapists working with children and young people who have been sexually abused were explored in open-ended interviews using a qualitative methodology, namely Grounded Theory (Strauss & Corbin, 1998) to analyse interview material. Interviews were conducted and analysed sequentially allowing identification of emerging themes which were carried into subsequent interviews. Two core categories emerged in this study. The first of these encompassed participants' responses to, and means of coping with, clinical work. The second core category, described as cross-over, incorporated emotional and psychological responses of therapists which carry-over from their work into their personal lives.

Within the first category, therapists' experiences of the empathic process were considered as well as the role of knowledge and understanding in coping with abuse work. The importance of having a balance within clinical work was emphasised. Differences in the way in which therapists distinguish their experiences of working with child victims of sexual abuse from 'normal' experience were apparent. Within this category there was also evidence of therapists' positive beliefs about their work and admiration of human survival in the face of trauma.

Within this category it was also apparent that responses to this work were not confined to the workplace and aspects of this may intrude into the therapists' own reality. These included having fears for the safety of their own or other children, experiencing altered beliefs in others or about the world. The impact of experiencing negative life events on therapeutic work was also included within this category. Coping with the emotional impact of therapeutic work within work included avoidance, such as distracting oneself.

Further evidence of the impact of therapeutic work on therapists' own reality was found within the second core category of cross-over. Included in this category were

examples of therapists' altered beliefs about the world, or other people; intrusive experiences such as thoughts and images; and issues relating to their professional role outside of work. Ways of coping with these experiences included deliberate avoidance of abuse-related material, having a healthy lifestyle and making use of personal therapy/ supervision.

Six other main categories were also identified. These were training, supervision, team working, the therapeutic frame, participants' first experience of working with abuse, and their route into working with child victims of abuse. These categories, although important to therapists' experiences, did not emerge as the strongest within the methodology adopted here.

The emergence of the two core categories suggest that, in this sample at least, there is a strong emotional impact to engaging in therapeutic work with child victims of abuse, which may extend into therapists' emotional life and ways of coping outside work.

These findings were then interpreted from a psychodynamic perspective, in an attempt to provide a theory of therapists' experiences which is grounded in the data. This highlighted the role of transference, counter-transference, and projective identification within therapeutic work with child victims of sexual abuse to account for the emotional experiences/ transformations reported by the therapists in this study.

4.1 Reflections on present findings

The importance of both owning one's own beliefs (Elliott, Fischer & Rennie, 1999) and reflecting on oneself as researcher (Lincoln & Guba, 2003), is emphasised within the qualitative research paradigm. Throughout this study I kept a journal of my experiences both in my clinical work and in this research process. This journal was

coded and key themes from it were identified. As researcher, I would like to consider three particular aspects of my experience which I feel give some perspective on my stance and, by implication, on the present findings.

Clinical experience

For the duration of my final year in clinical training (thus the duration of this thesis) I have been working in a child sexual abuse team as my clinical placement. That I chose then to do a thesis considering the personal impact of this work on therapists was not an entirely random event! Undoubtedly I had some fears for myself about whether I could personally cope with this work, based on my own assumptions of the difficulties of it. Nonetheless, I also came to this work, and this thesis, with a fair degree of naivety. I had virtually no clinical experience of working with clients who had been sexually abused and was also new to thinking about this from a developmental and/ or psychodynamic perspective.

At the beginning of my placement I experienced quite strong emotional reactions to the work, including horror, anger and awareness of the awfulness of abuse. I often felt inadequate as a therapist, was daunted by the prospect of trying to support these young clients and worried about making mistakes in therapy. In this early stage I worried about how I would cope with my emotional responses to my clients but was also aware of needing to contain my own anxieties. At this stage I appeared to be more of an observer of this work and was quite reticent about allowing myself to experience the emotional impact of it.

With continued experience I still worried about my capabilities as a therapist but was able, for instance, in and through supervision, to focus less on technical aspects of my work and more on my emotional responses. Further on in my placement I became aware of changes in my own life not dissimilar to those described by the participants in my study. I started to feel differently, for instance, more protectively, towards

children in my family and noticed some differences in how I thought about others' outside of work. With increasing experience I also worried about becoming desensitised to the realities of abuse.

Theoretical model

As a clinical psychology trainee I have learned much about cognitive behavioural theory and therapy. The final year of my training introduced me to a number of other therapeutic approaches. Although I enjoyed and felt challenged by this aspect, I also struggled with the uncertainty of not really knowing which approach worked for me.

I became interested in psychodynamic ideas and part of my placement involved using this model to inform my clinical practice. This was another area of difficulty for me; trying to step away from the predominant model whilst grappling with my appreciation of these new concepts. Learning about psychodynamic theory, and indeed the qualitative research paradigm, occurred in parallel to this research process. Therefore my understanding developed as the interviews progressed, and as I gained more clinical experience.

Interview process

In approaching my participants, I was curious to hear of their experiences but I was however fearful of the unknown aspect of this type of research. As I review my journal I am reminded of the difficulties I experienced in conducting these interviews. In early interviews it is apparent that my interests (biases) were in themes relating to more contextual aspects of people's experience, such as training or supervision. I was surprised by the way that the interviews then became more focused on personal aspects of people's experiences. However I often struggled with how to explore or understand these in the context of the interview, partly linked to my concurrently developing understanding of dynamic therapeutic processes. I was also acutely aware of my own limitations in terms of clinical experience and my lack of familiarity, and

comfort with the research methodology. I became aware, mainly through supervision, that throughout my interviews I was often reticent about exploring particular themes, particularly ones relating to distressing aspects of participants' experiences. In retrospect I think this reflects my fears of hearing things which I felt would distress me or put me off of the work I was doing.

My own emotional responses and reactions to the interviews were in many ways linked to my level of identification with what people told me. I was, therefore, variously shocked, surprised and comforted by things I heard, which either I did not want to imagine for myself, had not considered before, or could easily recognise in myself. This study does not purport to provide a purely objective account of these interviews. Consequently I hope this personal reflection provides some flavour of my (subjective) stance as participant in this research process, as against observer of it.

4.2 Implications of the present findings

The literature on therapeutic process and traumatisation suggests that there is a difference between newer versus more experienced therapists in their response to trauma work, specifically that newer therapists are more vulnerable to becoming traumatised (Neumann & Gamble, 1995, Pearlman & Mac Ian, 1995). Differences in the experiences of therapists who were newer to abuse work and those who have been working in this field for several years were apparent in this study. Two in particular are of interest.

The first relates to the empathic process. Therapists in this sample with more experience showed evidence of robustness, a capacity defined in this study as enabling them to experience emotion in therapeutic work without becoming overwhelmed by this. Newer therapists in comparison appeared to struggle more with their emotional responses. This seemed to relate to their awareness of the importance of an emotional understanding for therapeutic work but also an apparent fear of being

emotionally overwhelmed. Although we can only compare these differing experiences and must bear in mind the small sample size, it seems that the stance of the experienced therapists may be significant as these are therapists who have sustained working in this field for, in some cases, up to twenty years.

Anecdotally these therapists offered reflections on their earlier responses to this work. They identified that these had changed and were now less emotionally intense. They often described having become 'desensitised'. Such a process of change in responding to emotional aspects of the work seems important to understand more fully and cannot be deduced from the present study. One hypothesis might be that with increasing clinical cases, therapists are able to identify their emotional responses with previous cases thus enabling them to remain more emotionally distant. It cannot be assumed that those newer therapists who were interviewed will remain in this work. However this would seem to be a fruitful area of further research, that is, to employ a qualitative methodology in a longitudinal design to track individual therapists' developing experience of the work and how they cope with this. The need for longitudinal research focusing on processes of change is supported in several of the studies concerned with therapist traumatisation e.g. Jenkins & Baird (2002); McLean et al, (2003); Steed & Downing (1998).

Ways of coping with the emotional impact of this work also appeared to vary between newer and more experienced therapists. Newer therapists however did not ascribe any particular intention to their use of coping strategies, nor did they link the use of these to the emotional impact of their work. It has been suggested that newer therapists are more vulnerable to being traumatised by their work partly because they may not be aware of the dynamic processes occurring in therapy and may not employ intentional coping strategies to deal with the emotional impact of this (Neumann & Gamble, 1995). It is argued however that their lack of deliberate coping strategies may be a significant indicator of the impact of this work i.e. by recognising when their use of coping strategies changes.

Experienced therapists in comparison demonstrated an intentional use of coping strategies which they related to the negative emotional impact of the work, thus enabling them to restore an emotional equilibrium. The need to, ostensibly, make oneself feel better as a consequence of this work, and not just from time to time, would suggest that this reflects a transformation in the therapist's inner experience. In trying to enhance our understanding of why this might be, the present study suggests that therapists' strong counter-transference reactions and identification may impact upon their self-understanding and contribute to a transformation of inner experience. The proposal is that that these 'normal' dynamic therapeutic processes have a considerable impact on therapists, the power of which relates to the particular dynamics of therapy with victims of abuse.

It is evident from the literature that much of the reparative aspect of therapeutic work with adult survivors, and child victims of abuse, is the context of the therapeutic relationship (Bowlby, 1988; Briere, 2002; Herman, 2001; Pearce & Pezzot-Pearce, 1994). That is, unspoken aspects of abuse such as the betrayal of trust, disempowerment and rejection must, it is suggested, be reconciled within the context of a relationship that disconfirms the child's internal working model of relationships (Bowlby, 1988; Dozier et al., 1994; Pearce & Pezzot-Pearce, 1994). Although these can be talked about, the therapist must consistently demonstrate their trustworthiness in their responses to the child, and contain attempts by the child to sabotage such positive relational aspects (Catherall, 1991). It is acknowledged that these processes occur (mostly unconsciously) in the therapeutic relationship and place considerable emotional demands on the therapist (Catherall, 1991; Dozier et al., 1994; Marmaris et al., 2003; Neumann & Gamble, 1995; Pearce & Pezzot-Pearce, 1994).

The aim of this study was to understand whether the experiences of therapists working with child victims of sexual abuse are similar to those who work with adult survivors. The present study proposes that dynamic processes within therapy such as counter-transference and projective identification are used to interpret the experiences of therapists in this sample. What is of interest is whether working with children who

have been abused has a qualitatively different impact. In considering the terminology alone, the distinction between adult 'survivors' and child 'victims' implies something about beliefs or attributions, at a societal level, of the particularly damaging and enduring impact of child abuse. It would therefore be interesting to explore whether identification with the 'vulnerable' child is an important aspect of therapists' experiences when compared to those who work with adult survivors.

It is proposed that the reason some therapists experience disruptions in their interpersonal relationships as a consequence of this work, may relate to their identification with a particular aspect of the child's emotional experience, or the emotion experienced in the therapeutic processing of this, which has a personal resonance for them. Nonetheless quantitative research, particularly in relation to therapist traumatisation, often attempts to relate therapist's negative symptoms or experiences to one aspect, usually the therapy. The limitations of this are recognised within these studies and the need to consider factors out with the therapeutic work is highlighted. This conclusion is reiterated here.

Therapists' counter-transference and ways of coping with their emotional experience may also reflect aspects of their relational schema. Their relational history, particularly early attachment, and core relational, experiences will have shaped aspects of their current interpersonal relating. The impact then of a therapist's attachment style is one aspect which seems worthy of further investigation. Attachment theory (Bowlby, 1973), as an explanatory framework, integrates cognitive, relational and affective components from a developmental perspective. Studies which look at therapists' attachment style tend to do so in the context of understanding the impact of security of attachment on therapist behaviours, and by implication, on the treatment process – specifically the impact on their counter-transference behaviours (Ligiéro & Gelso, 2002) and on the nature of their therapeutic interventions (Dozier et al., 1994).

Marmaris et al. (2003) propose that insecure attachment status (specifically fearful or preoccupied) may interfere with the therapist's processing of counter-transference reactions. They also suggest that over-identification with a client may be related to interpersonal difficulties experienced by therapists associated with the insecure attachment types. These studies tend also to assume that this has a negative impact on therapeutic process and outcome although, interestingly, this assumption is not specifically tested within these studies.

Treatment outcome is not a focus of the present study. However, it is acknowledged that adult attachment status may relate to recognition, and regulation, of emotion in therapists (Ligiéro & Gelso, 2002). That therapists' attachment status may affect their internal processing of counter-transference, or their responses to interpersonal aspects of the therapeutic relationship (i.e. in terms of relational schema), is of importance to the present study. Since it is proposed that transference, counter-transference and identification are powerful aspects of therapists' experiences, exploration of therapists' adult attachment status, might further our understanding of their internal experiences both within and outside their therapeutic work. Equally, the contribution of attachment theory to understanding adaptation to early abusive experiences might also help to explain why some survivor therapists, for example, are more affected by their therapeutic work than others. This might provide a more integrated understanding of their experiences, rather than attempting to separate out abuse history as a single vulnerability factor (e.g. Benatar, 2000; Steed & Downing, 1998).

As the present study suggests, exploring the experiences of therapists not only develops our understanding of processes which may contribute to the so-called traumatisation of therapists, it also highlights the personal impact of this work. The therapist as a person, and a 'variable', is complex and dynamic, nonetheless, as Lemma (2003) contends, cannot and should not be ignored.

4.3 Methodological critique

A final aspect of this discussion is to consider the implications and limitations of the methodology. With respect to the present sample of participants, determination of the final sample size is relative to the development, and eventual saturation, of themes within the interviews. In the present study it was evident that, in later interviews, the themes which were emerging were recurrent, and not new. Such circularity was indicative of saturation (Strauss & Corbin, 1998). That there was only one man in the final sample reflects the gender-ratio of therapists working in the child sexual abuse teams, nonetheless this precludes discussion of particular therapeutic dynamics, such as identification, which may be associated with gender (Pearlman & Saakvitne, 1995).

The range of professional training of the participants was also concordant with proportions in the teams. However, it is acknowledged that they may not all work within the same therapeutic approach. The extent to which this is significant to the present findings requires further comparative investigation.

The analysis of material from the interviews is not a finite process. Further analysis of the present interviews focusing on the semantic and symbolic aspects of participants' narratives could enhance the present findings. Furthermore, developing and restructuring the themes from these interviews to construct an interview which could be applied to another sample of therapists working in this field would provide support for its transferability (Denzin & Lincoln, 2003).

Charmaz (2003b) is critical of grounded theorists who rely on one–off interviews. She argues that these preclude the researcher from becoming fully immersed in the experiences and feelings of participants. This can lead to a "partial, sanitised view" of their experiences (Charmaz, 2003a, p. 275). It is acknowledged then that to strengthen the present analysis re-interviewing participants may have been useful,

both to deepen understanding of developing themes and increase their (and my) comfort with the interview process. Unfortunately this was not possible given the time constraints of this research.

Establishing the credibility of one's grounded theory is emphasised (Barker et al., 2002; Denzin & Lincoln, 2003; Elliott et al., 1999). Presentation of the current findings to the participants would be considered a reliable way to establish their credibility, that is, the extent to which this analysis and interpretation fits with their experience. As Strauss & Corbin (1998) highlight, although a grounded theory may not fit every aspect of participants' experiences, the larger concepts should be applicable and recognised by them. Again, due to limited time, this was not feasible before completion of this thesis. However, presentation to the participants is planned.

Finally, studies relying on unstructured interviews have been criticised for a lack of reflexivity in the process of interpretation of data (Fontana & Frey, 2003). It is hoped that the author's theoretical and personal stance has become evident throughout this thesis, allowing some inference on the reader's part about what has influenced the analysis of interview material presented here.

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6 Appendices

6.1 Appendix I – Participant Information Sheet

CSA NETWORK RESEARCH OUTLINE

Following the meeting of the network (25th November 2003), (YPU), (Rillbank/YPU) and Gillian Affleck (CVC) met to discuss the planned research. It was felt that it might be useful at this stage to clarify some of the issues surrounding the research so as to allow consideration of it in individual teams and the wider network.

The impetus for this research was generated by the network members and is therefore owned by them.

Aim

The aim of the research is to develop an understanding of the individual experiences of therapists working with children and young people who have been sexually abused and, from that, to identify possible supervision or training needs.

Methodology

This will be examined using a qualitative research methodology, Grounded Theory. The principle underlying this is to explore the actual experiences of people working in this area and to develop and test hypotheses based entirely on what people tell us. We are therefore concerned with hearing about individuals' experiences as *they* see them, and not imposing questionnaires or pre-selected measures.

Procedure

The initial phase of the research will involve interviewing 6 to 10 network members. These will be open-ended interviews which will take place between January and June 2004.

A second phase of interviews with remaining network members will follow on from the initial phase and will run approximately from March until late summer.

Time

Due to the nature of the methodology, interviews will be necessarily open-ended. It would be envisaged that they may take 1 to 2 hours. It is important that the interviews come to a natural conclusion, consequently, we would ask that if you are being interviewed you scheduled it for the end of the day.

Who will be interviewed?

The interviews will take an individual, developmental focus being primarily concerned with therapists who work with children who have been sexually abused, looking at how they came to this work and exploring their experiences of it.

The initial interviews will not include therapists working with children or young people who display sexually inappropriate behaviour. The reason for this is that the research literature on this client group is quite distinct to that of victim work, reflecting the different dynamics which occur when working with these clients. For research purposes it is, therefore, simpler to focus on therapists working predominantly with victims. We are aware however that issues of working with victims who are also sexually inappropriate may arise in interviews, and that there are staff who work with both client groups.

Who will do the interviewing?

The first set of interviews will be conducted by Gillian Affleck. Gillian is a final year trainee clinical psychologist on the Edinburgh University course who has chosen to do her specialist placement at the CVC. Gillian is relatively new to working therapeutically with this client group and is interested to hear more experienced colleagues' reflections on their work.

The interviews and analysis which Gillian carries out will form the basis of her doctoral thesis but also, as part of the CSA network over the coming year, will be her

contribution to it. Gillian's thesis supervisor is who is also the identified research consultant for the wider research.

The second phase of interviews will be carried out by Clinical Psychologist at the YPU. is keen to be involved in this research and brings the perspective of an experienced clinician working in the field.

What will happen to the findings?

The final phase of the research will involve feeding back and discussing the findings from the analysis of the interview material with the teams. Ideas raised in that discussion will be included as part of the overall findings. It is hoped that this discussion will raise awareness of issues for therapists which may become a focus for further training or development.

This research is likely to be an evolving process with opportunities for other team members to become involved and which, it is hoped, will have a meaningful impact on individual therapists and the network as a whole.

We would be most grateful if you could take some time to look over this outline and discuss it within your teams. If you have any questions or concerns about this, please contact either Gillian Affleck or

Many thanks.

Gillian Affleck

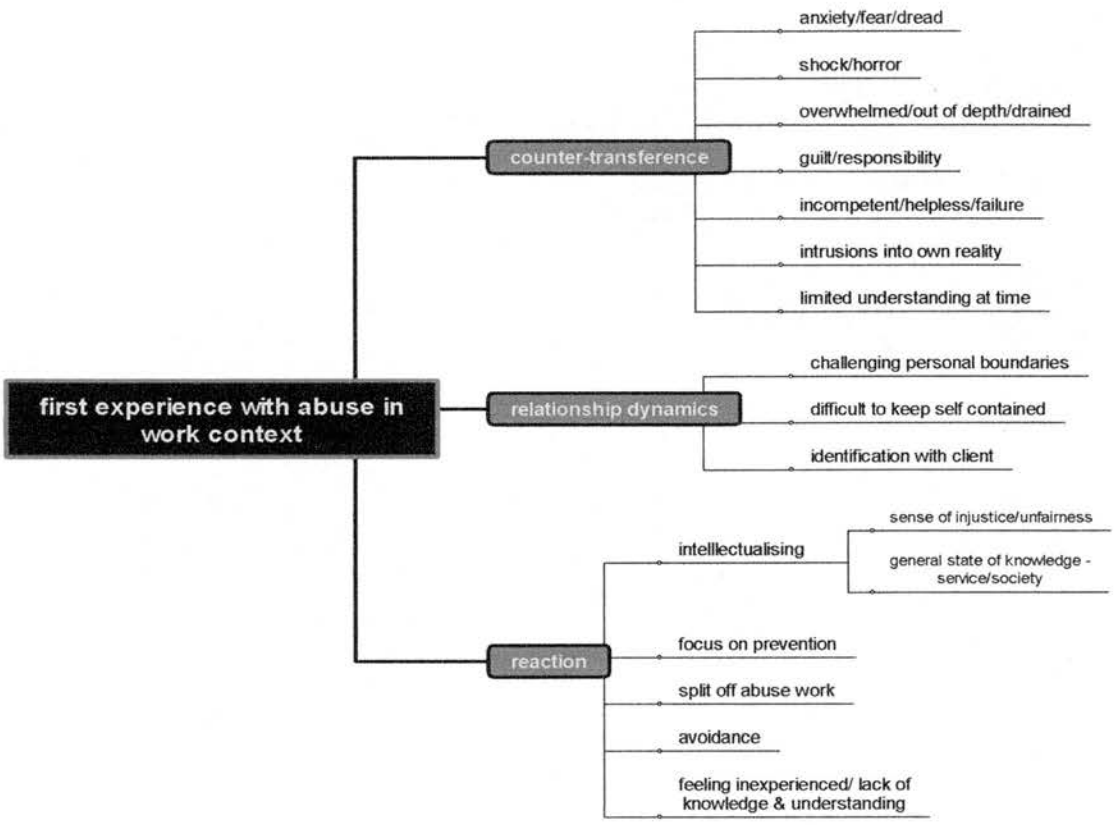
Trainee Clinical Psychologist

CVC

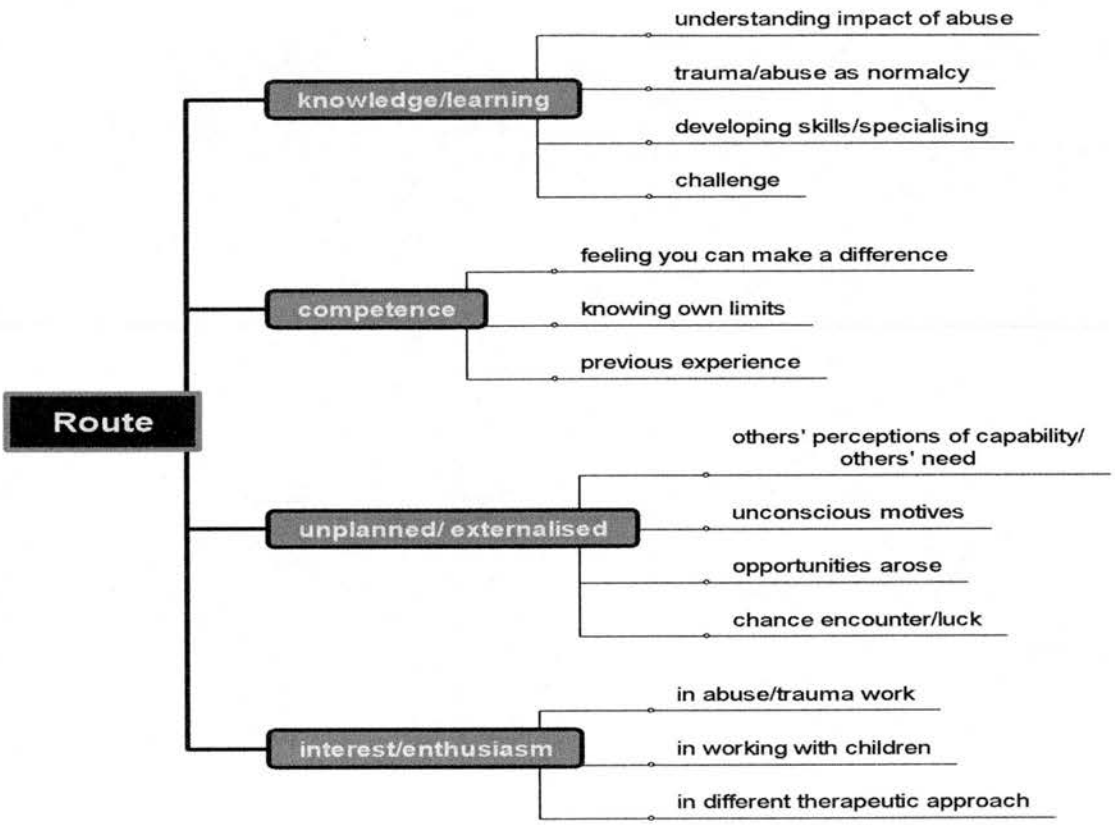
6.2 Appendix II - Percentage of interviews taken up with categories

Participant Number	Interview length (minutes)	Responses/ coping	Cross-over	Route	Supervision	Team	Training	First experience	Therapeutic frame
1	**59**	**32**	**14**	**1**	**0**	**3**	**8**	**10**	**0**
2	**112**	**43**	**7**	**9**	**5**	**7**	**16**	**3**	**3**
3	**88**	**43**	**21**	**10**	**4**	**5**	**3**	**1**	**8**
4	**68**	**40**	**10**	**4**	**5**	**8**	**7**	**6**	**3**
5	**66**	**34**	**27**	**9**	**1**	**6**	**1**	**3**	**2**
6	**84**	**50**	**33**	**6**	**2**	**3**	**3**	**0**	**3**
7	**84**	**51**	**27**	**7**	**1**	**10**	**2**	**5**	**4**
8	**66**	**43**	**23**	**3**	**1**	**5**	**3**	**5**	**9**
9	**116**	**30**	**35**	**4**	**5**	**13**	**4**	**1**	**1**
10	**113**	**52**	**23**	**3**	**2**	**10**	**1**	**8**	**7**

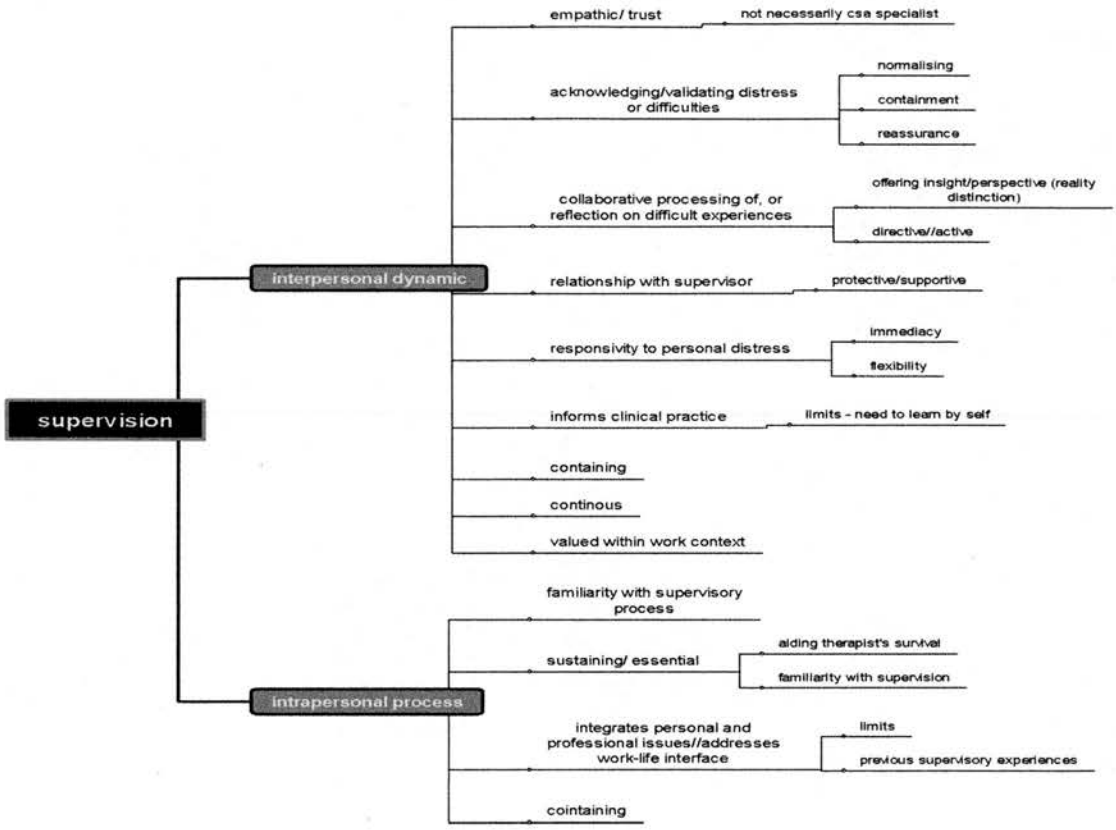
6.3 Appendix III Overview of main category – First experience



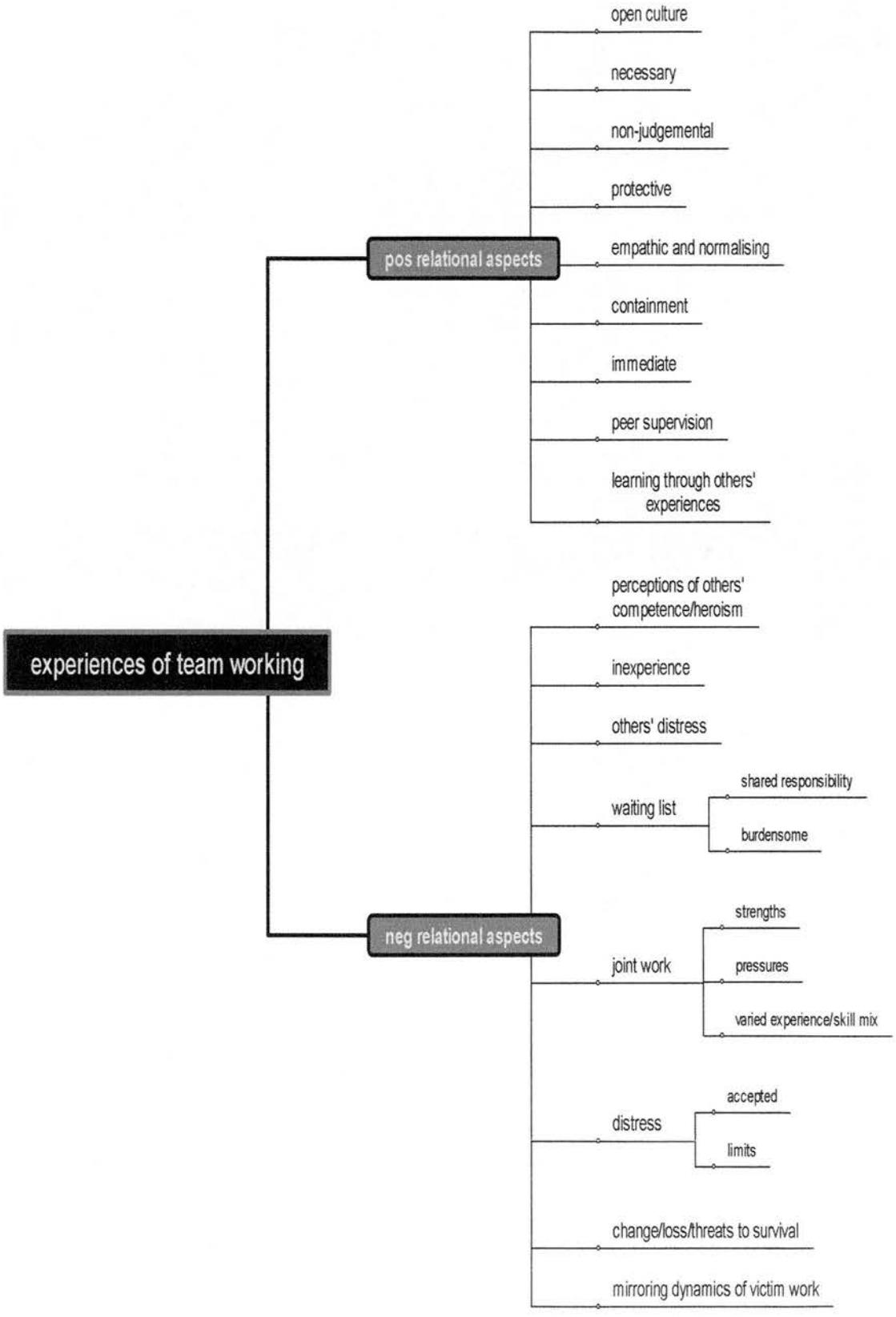
6.4 Appendix IV Overview of main category - Route



6.5 Appendix V Overview of main category - Supervision



6.6 **Appendix VI** Overview of main category – Team working



6.7 Appendix VII - Overview of main category - Training